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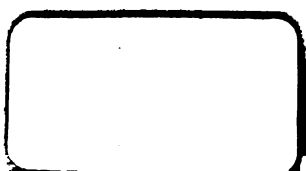
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MONTHLY.

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EDITED BY

CLARENCE BARTLETT, M.D., WM. B. VAN LENNEP, A.M., M.D., AND  
WM. W. VAN BAUN, M.D.

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THE  
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THE ALBUMINURIAS OF PREGNANCY.—FIRST PAPER.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

(Professor of Chemistry and Toxicology in the Chicago Homoeopathic College.)

I. CLASSIFICATION.

I USE the plural—albuminurias—advisedly, and shall attempt to prove that it is possible for a score of them to occur during pregnancy; that, in order to make a prognosis in any individual case, we must be able to account for the particular kind of albuminuria which the patient presents; lastly, that by means of knowledge of the patient's history, observation of her present condition, quantitative examination of the urine, and microscopical examination of the urinary sediment, a decided prognosis can be given in many cases in which not long ago a prognosis was the veriest guess-work; that, in consequence, a system of treatment can be carried out which shall be just and fair, with reference to the patient, neither too mild nor unnecessarily severe.

A general classification of albuminurias (on next page) will be convenient for reference during the course of the paper.

A few words in explanation of the table are necessary, owing to the brevity of the terms used.

I. *Paroxysmal Albuminuria*.—Condition in which albumin is found at same particular time of day, but not at other times in notable quantity. Usually none after rest in bed. Synonymous with cyclical and postural albuminuria.

*Dietetic*.—After meals, or after meals and exercise.

TABLE I.  
CLASSIFICATION OF ALBUMINURIAS.

ANORGANIC.*	ORGANIC.	
	<i>Extra-renal.</i>	<i>Renal.</i>
Temporary. { <ul style="list-style-type: none"> <li>(a) Paroxysmal (cyclic).</li> <li>(b) Dietetic.</li> <li>(c) Muscular.</li> <li>(d) "Hepatic."</li> <li>(e) Vaso-motor (neurotic).</li> <li>(f) Circulatory.</li> </ul> Persistent. Simple persistent without casts.	1. Urethral. 2. Prostatic. 3. Spermatic. 4. Vaginal. 5. Vesical. 6. Ureteral. 7. From lesion in kidney-pelvis.	I. Degenerative. { <ul style="list-style-type: none"> <li>1. Acute parenchymatous.</li> <li>2. Chronic parenchymatous.</li> <li>3. Chronic parenchymatous in diabetes.</li> </ul>
Albumin at certain times found in the urine, usually in small quantity or mere traces (but possibly abundant). Albumin not accompanied by renal casts other than occasionally a stray hyaline cast. Specific gravity of 24 hours' mixed urine, 1015 to 1025. Patients (I., a, b, c) usually young. No signs of cardiac hypertrophy or high arterial tension. No gout, no retinal change.	Albumin in small amount, or mere trace, due to presence in the urine of <i>bacteria</i> , <i>epithelia</i> , <i>spermatia</i> , <i>prostatic</i> or <i>leucorrhoeal</i> fluid; <i>pus</i> , or <i>blood</i> , from elsewhere than the kidney parenchyma.	II. Inflammatory. { <ul style="list-style-type: none"> <li>4. Acute exudative.</li> <li>5. Acute diffuse.</li> <li>6. Sub-acute diffuse.</li> <li>7. Chronic diffuse.</li> <li>8. Acute interstitial.</li> <li>9. Chronic interstitial.</li> <li>10. (Gouty.)</li> <li>11. Suppurative interstitial</li> </ul>
		III. Hyperæmic. { <ul style="list-style-type: none"> <li>12. Acute.</li> <li>13. Chronic (cyanotic induration).</li> </ul>
		IV. From infiltration. { <ul style="list-style-type: none"> <li>14. Lardaceous.</li> <li>15. Syphilitic.</li> <li>16. Scrofulous.</li> <li>17. Tuberculous.</li> </ul> V. From growths, parasites, or cysts. <p>Albumin from trace to great abundance with tube-casts. Tube-casts may be absent, but sp. gr. will not be 1015 to 1025. Possibly pus and blood with abundant albumin. Signs of cardiac hypertrophy or arterial tension.</p>

*Muscular.*—After vigorous exercise. To the three above mentioned the general term "physiological albuminuria" has been applied.

\* I take the liberty of using this word to describe certain albuminurias which, so far as we know, are not the result of organic lesion.

*Hepatic*.—During digestive disturbances; slight jaundice.

*Vaso-Motor*.—In over-work, ill-health; caused by masturbation. Also called neurotic.

*Circulatory*.—Found in cases to be explained best on the ground of alteration in the specific gravity of the blood, as in corpulent elderly persons, and sometimes in pregnancy. To the last three just mentioned the term “functional” has been applied.\*

II. *Albumin* is found in the urine in diseases of the urethra, prostate, vagina, bladder, ureters, kidneys and pelvis, being due to presence of bacteria, epithelia, pus or blood. (Albumin is also found in urine containing prostatic or seminal fluid.)

III. *Albumin* is found in the urine in various renal lesions, which, for convenience, may be classified as degenerative, inflammatory, hyperæmic, etc. These terms are by no means above criticism, it is true, but something must be done to indicate differences, not only pathological, but clinical as well, in the various albuminurias due to renal lesion. I use the term “degenerative” to describe albuminurias due to a *renal transformation*, in which the *epithelial cells* † lining the uriniferous tubules lose the power of eliminating the products of tissue change and pass through various retrograde conditions (cloudy swelling, granular change, fatty transformation), but not from what we define as *inflammation*, properly speaking, in course of which we expect to find determination of blood, stasis, escape of liquor sanguinis, and so on.

I classify an “acute exudative nephritis” on the authority of Delafield. Clinically, I am inclined to the view of Tyson, that it is difficult to distinguish the exudative from the diffuse.‡ I use the term “diffuse” to describe an inflammation in which there is not only change in the epithelium of the tubules, but also in the inter-tubular (interstitial) tissue, and, in some cases, vascular thickening as well. I adopt the term “sub-acute” to describe that form of nephritis which, while clinically resembling in some respects (anæmia, nausea, dropsy) acute cases, nevertheless is long continued with per-

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\* Inasmuch as there are objections to the terms “physiological” and “functional,” I have described all these albuminurias by the general term “unorganic.”

† I restrict the term “degenerative” to those conditions in which there is cedematous but not inflammatory change in the intertubular tissue.

‡ Delafield uses the term “exudative” to describe an inflammation in which the bloodvessels play an active part. The serum, fibrine and pus cells are derived from the contents of the bloodvessels, while changes in the tissues themselves are absent or secondary.

manent changes in the kidneys, and, in consequence, change in the *quality* of the urine, the *percentage* of solids growing smaller.

I use the term "suppurative interstitial" to describe an inflammation in the kidney secondary to affections of pelvic organs, as cystitis. Other terms for what is clinically the same thing are ascending nephritis, obstructive nephritis, surgical kidney. Lastly, in alluding to renal hyperæmia, I mean merely engorgement of the renal vessels, *active* or acute when the arterial capillaries and tufts show the greatest engorgement, *passive* or chronic when the large veins are found to be engorged. Inasmuch as there is no general agreement as to the use of several of the various terms, I trust that I will be excused for thus going into particulars.

#### PATHOLOGY.

I see no reason for regarding the pregnant woman as, for some unaccountable reason, exempt from the various albuminurias to which ordinary flesh is heir. If albumin appears in the urine it can be referred, after careful examination of the urine and of the patient, to one of the two general classes of Table I., Anorganic and Organic. If the albuminuria is anorganic, it will probably be either dietetic, hepatic, neurotic, or circulatory. If the albuminuria is organic, it may be shown, by methods which I shall soon describe, whether it is extra-renal or renal.

Now, when albuminuria of *renal* origin is found in the course of pregnancy, it is customary to say that the patient has "puerperal nephritis." But there is no "nephritis" common to all pregnant women, *i.e.*, which all pregnant women have when the kidneys themselves are involved. The phrase "puerperal nephritis" is convenient, but conducive to looseness and routine in both prognosis and treatment. In proof of my assertion I submit quotations from the following authorities in alphabetical order, italics my own :\*

Delafield :† acute diffuse nephritis is the most important *variety* of nephritis in pregnancy.

Frerichs :‡ puerperal albuminuria is due to an *acute nephritis*.

Leyden :§ it is neither acute inflammation nor chronic congestion, but *arterial anæmia* and *degenerative changes*; in some cases ordinary Bright's disease is developed.

\* See also cases from my own practice referred to later.

† *Ann. of the Univ. Med. Sci.*, 1889, G., 6, iii.

‡ *Ann. of the Univ. Med. Sci.*, 1888, vol. i., p. 482.

§ *Ann. of the Univ. Med. Sci.*, 1888, vol. i., p. 482.

Ralfe :\* *parenchymatous changes*, frequent recurrence leads to chronic nephritis and development of *large white kidney*, etc.

Rosenstein :† no active nephritis, but only a *chronic congestion*, due to the pressure of the pregnant uterus on the veins.

Saundby :‡ the most common causes (of obstructive nephritis) "are *pregnancy*," etc.

Weinbaum :§ recognizes *four forms* :

1. Dropsy without renal lesion. 2. *Swelling and degeneration* of the renal epithelium, a transitory condition. 3. *Acute exudative nephritis* (temporary). 4. *Acute diffuse nephritis*.

I cannot believe that the men just quoted are either vaporing triflers or common liars. On the other hand, I see no reason for assuming that some particular one of them is unique and peerless in his observations, whilst all others are, in comparison, mere grovellers in a dismal swamp of hopeless error. I will not denounce the opinions of any or all of them who may not possibly have seen the same pathological conditions which have come under my own personal observation. It is more probable that there is a grain of truth in every one of them, than that all are totally wrong or that some particular one is the infallible authority.

In other words, it is probable that the albuminurias of pregnancy which these men have seen are not so very different from other cases in practice. That the pathological conditions are made various by a host of circumstances, among which heredity, syphilis, climate, status in society, "drugging," etc., play an important part.

Hence, I unconditionally reject the phrase "puerperal nephritis," and abjure the use of the pronoun "it" in referring to a score of conditions possible in the course of pregnancy. [I think that it will be proved in time that pregnancy is *never*, strictly speaking, a *cause* of lasting nephritis, but merely aggravates a pre-existing one, as Lécorché now suggests. If there is no pre-existing nephritis, albuminurias which arise during pregnancy, will, with proper care and attention, disappear after delivery. I do not use the term "nephritis" synonymously here with "albuminuria," but to describe true inflammatory conditions.]

In consequence of my rejection of the phrase "puerperal nephritis," I must needs tabulate the albuminurias which from study and ex-

\* *Diseases of the Kidneys*, 1885, p. 246.

† *Ann. of the Univ. Med. Sci.*, 1888, vol. i, p. 482.

‡ *Lectures on Bright's Disease*, 1889, p. 231.

§ *Ann. of the Univ. Med. Sci.*, 1888, vol. i, p. 483.

perience I deem pregnant flesh to be heir to. I will include in my list not only those cases coming under my own observation, but those reported by others whom I deem worthy of credence.

TABLE II.  
THE ALBUMINURIAS OF PREGNANCY.

*Anorganic.*

Dietetic.  
Hepatic.  
[Paroxysmal.]  
Neurotic.  
Circulatory.

Extra-renal. { Urethral.  
                  { Vaginal.  
                  { Vesical.  
                  { Ureteral.  
                  { Due to pyelitis.

*Organic.*

Renal. { Acute degeneration.  
          { Chronic degeneration.  
          { Acute exudative inflammation.  
          { Acute diffuse inflammation.  
          { Sub-acute diffuse inflammation.  
          { Chronic diffuse inflammation.  
          { Chronic interstitial.  
          { Suppurative interstitial.  
          { Chronic hyperæmia.  
          { Syphilis of the kidney.  
          { Complicated cases.

*Authorities and General Reasoning.*—Dietetic albuminuria: Various obstetricians; see HAHNEMANNIAN, November, 1889, p. 731.

*Hepatic Albuminuria.*—No reason why the pregnant woman should be exempt from albuminuria of disturbed digestion.

*Paroxysmal.*—Same reasoning; also case of Ralfe, in his book, 1885, p. 539.

*Vaso-Motor or Neurotic.*—Lantos in *Archiv. für Gynäkologie*, vol.

xxxii., Part 3. (Synopsis in *British Medical Journal*, January 12, 1889.)

*Circulatory*.—Ralfe, *Diseases of the Kidneys*, 1885, p. 539.

*Urethral*.—No reason why pregnant women should be exempt from urethritis.

*Vaginal*.—I have observed, in scores of instances, traces of albumen due to leucorrhœal admixture.

*Vesical*.—The same when heavy sediment of epithelia from desquamation of bladder; also in severer cystitis when pus is present.

*Ureteral*.—Indirectly from dilatation; editorial in HAHNEMANNIAN, November, 1889, p. 731. Directly from inflammation and presence of pus in urine; quite likely when there is pyelitis.

*Due to Pyelitis*.

*Acute Degeneration*.—Weinbaum, already quoted; also Porter (*Renal Diseases*, 1887, p. 104); and Leyden, already quoted.

*Chronic Degeneration*.—Porter, 1887, p. 104.

*Acute Exudative Inflammation*.—Weinbaum.

*Acute Diffuse*.—Weinbaum, Delafield.

*Sub-Acute Nephritis*.—Ralfe, *op. cit.*, p. 247.

*Chronic Diffuse*.—Various authorities, as Ralfe, note a tendency eventually to small kidney, which is possibly rather that of the diffuse group than purely cirrhotic. (See Porter on Errors in mistaking Diffuse Group for Cirrhosis, *op. cit.*, p. 93.)

*Chronic Interstitial*.—Pale, granular or atrophic kidney, according to Ralfe, in process of time; see above.

*Suppurative Interstitial, Ascending Nephritis; Obstructive Nephritis*.—Saundby, *Bright's Disease*.—1889, p. 236.

*Chronic Hyperæmia*.—Rosenstein (first two editions), already quoted.

*Syphilis of the kidney* has not received the attention it deserves. It has been claimed by Jaccoud that renal syphilis may show itself early by simple persistent albuminuria or by acute diffuse nephritis; or (Wagner), on a chronic condition, there supervenes an attack of acute diffuse nephritis, with hæmaturia. It is quite possible that some deaths from nephritis, during pregnancy, may be due to syphilis, either previously latent or contracted from the husband; the latter would seem especially likely in primiparæ.

*Complicated Cases*.—These are probably far more common than generally realized. Every one knows, for example, how liable is a patient with chronic hyperæmia to acute exacerbations. Chronic nephritis and lardaceous disease are found in the same patient. Other examples might be quoted.

## TRANSIENT ŒDEMA AND BILIOUS COLIC.

BY J. P. DAKE, M.D., NASHVILLE, TENN.

THE paper read before the Pennsylvania State Society by Dr. Clarence Bartlett, and published in the *HAHNEMANNIAN MONTHLY*, November, 1889, page 699, bringing forward some original deductions, as well as valuable observations upon certain forms of œdema, has called to mind some discoveries of my own that may prove of interest to the profession.

Something more than twenty years ago I was called upon by my old friend, Dr. Rush, of Salem, O., to assist in making a *post-mortem* examination in the case of a man who had died of suffocation, after a few hours' illness.

The patient had been in usual health all day, preparing to start off on a business trip on the morrow. In the night he was awakened by a constricted feeling in his throat, a sense of suffocation. Upon the arrival of Dr. Rush there were present the symptoms of obstructed larynx or trachea, as in membranous croup. All efforts to relieve the difficult breathing were ineffectual, and the patient died before counsel could be called or much done, he residing some distance in the country.

The examination was made about six or eight hours after death, and revealed no malformation, no false membrane, and very little apparent inflammation of the lining or the deeper tissues. There was present some collection of frothy mucus in the larynx and trachea. The epiglottis seemed to have been in a normal condition.

It was a question whether there had been a spasm of the glottis, or in the larynx or tube below, sufficient to shut off the breath; or whether, again, there had been a transitory œdema. If there had been an œdematous condition of the mucous membrane, the tumefaction had subsided with the loss of motion and heat at and after death.

The patient had been a strong and apparently healthy man, subject to no special form of disease, except bilious colic, of which he had experienced several attacks, though, so far as I now remember, he never discharged any biliary calculi.

A few years afterward, in this city, I had a patient subject to spells of bilious colic, a very robust, high-living man, who came to me one morning from the train, with his face swollen, as with severe urticaria. There had been itching and heat before and with the œdema.



The application of hot water and some internal remedy, which I do not now recall, soon afforded relief. This case reminded me of that mentioned above.

I had before me the following facts:

1. That in both subjects there had been violent attacks of what could not be diagnosed as anything else than biliary obstruction.

2. That in neither had there been a discharge of biliary calculi, so far as could be discovered.

3. That in both the obstruction was probably due to some other cause than a calculus.

4. That in both there was an immunity from colic during the presence of œdema or obstruction elsewhere.

Reasoning upon these facts, I came to the following conclusions:

1. That the patient of Dr. Rush died from œdema of the mucous membrane of the larynx or trachea, one or both.

2. That his attacks of colic had been due to sudden œdema of the membrane lining the biliary duct.

3. That my patient had colic from a similar œdema in the duct, a condition not unlike that revealed upon his face.

These discoveries in etiology led me to a solution of what had been a mystery to me—how it was that *china* could prove so efficient a remedy in bilious colic. I had great confidence in the professional judgment of my friend, Dr. David Thayer, of Boston, and yet I could not understand why he so insisted that he had cured and could surely cure bilious colic with *china*.

Proceeding by faith in the statements and figures of Dr. Thayer, and not by the pathogenesis of cinchona, as showing an ability to occasion the horrid tortures of that twisting, writhing complaint, I had experienced gratifying results from his much-praised remedy. But when I found the key to the etiological mystery I was not long in unlocking the therapeutic mystery. Over and over again have I known of persons having urticaria and local œdema induced by some form of cinchona, more especially by the sulphate of quinine.

For years past my homœopathic remedy for the œdema of urticaria, as well as bilious colic, has been cinchona bark, in trituration or quinine, in moderate doses. It is enough for me to know that the homœopathic relation exists between the pathogenic influence of the drug and the affection for which I am prescribing. I am content to let Dr. Lauder Brunton, Dr. H. C. Wood and others speculate upon the philosophy of the case, whether the fault and cure be in the liver, the stomach, the lymphatics, or the nerves.

Ten years ago, in reading the classic lectures of Dr. Murchison on the diseases of the liver, I made a note at the bottom of the page on which he gives a classification of the causes of biliary stricture. He mentions under one heading five causes, as follows:

1. Congenital deficiency.
2. Stricture from peri-hepatitis.
3. An ulcer in the duodenum.
4. Cicatrization of ulcer in duct.
5. Spasmodic stricture.

In my note, at the bottom of the page, I gave as an additional cause:

6. Oedema of the lining of the duct.

I firmly believe that what is usually termed bilious colic arises more frequently from this last condition or cause than from all others put together. I should mention, however, that other obstructing causes, such as calculus, hydatids and foreign bodies from the intestines, were noted by Dr. Murchison. Though he speaks of inflammation of the lining membrane of the duct, he does not recognize the oedema, arising and subsiding suddenly, as similar in kind to that often seen upon the surface of the human body.

In closing, I would refer to the case reported by Matas, mentioned by Dr. Bartlett, page 701, as showing the prompt curative action of quinine. The woman had oedema of the upper lip for two months, and it disappeared in two days, under the influence of that drug, and did not return. And I would remark that in cases of oedema of the glottis, or of the larynx or trachea, life may be saved by a prompt resort to intubation, as now being practiced in cases of croup, or by the older method,—tracheotomy,—the nature of the case not allowing time for curative medicinal action.

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## GYMNASIA AS A FACTOR IN PROPHYLAXIS.

BY DANIEL KARSNER, M.D., PHILADELPHIA.

(Read before the Homoeopathic Medical Society of the County of Philadelphia, September 12, 1888.)

"FROM the earliest date of its records, history contains numerous examples of the occurrence of disease, widely prevalent for periods of greater or less duration both among men and animals; the first known as epidemics, the latter as epizooties, significant terms derived from the Greek. These plagues were more or less limited in extent,

and more or less fatal, proportionally, at different times ; but appeared so obscure in their origin and history, and constituted so terrible an affliction, that both priests and poets, as well as the vulgar, were disposed to refer them directly to the wrath of the angry gods, the arrows of Apollo ; or to the malignant potency of some imaginary monster, as the Leonæan Hydra."

From those ancient dates to modern periods have these pestilences, more or less changed by conditions of evolution, been handed down from one generation to another, ever conforming to the same general laws giving rise to, and propagating them. And we, as medical philosophers, practitioners and hygienists, are confronted in this era with the startling and significant fact that, notwithstanding a limit has undoubtedly been placed upon their ravages, not a single well-known form has been blotted from the list. The mission of medicine has been to mitigate rather than stamp out disease ; the healing art is yet tentative, the science still in its infancy. Indeed, a careful survey of the field proves that the attempts to eradicate disease have resulted in what might be termed a magnificent failure. This is not said in any specious spirit, not in disparagement of the many noble deeds of our good brethren, the self-sacrificing physicians and surgeons, nor of the progress made, or making, in the science of healing. We cannot stand still ; we must learn ; but with all our boasted triumphs and splendid prestige, our great battles of the schools and pathies, our experiments and thousands of reported cases, we have not yet found the panacea—the cure-all. No ; nor even the cure for any disease. People suffer to-day just as they did away down the dim vista of the ages ago, from small-pox, ague, the various febrile affections, the pains and plagues that we have studied and classified and given names, treated with more or less relief, distinguished in a marvelously plain and ample etiology, but they are the same old poxes, fluxes, palsies, quartans and quotidians that plagued the people four thousand years ago ; irradicable then, irradicable now. We may modify but we cannot extirpate them. Do what we will they return to torment us, and so utterly helpless are we now to conquer malady that the wisest and best practitioners not only tell us to keep out pestilence by quarantine, but enlist the strong arm of the government to make the prevention system potent. It requires no very keen discernment to see in the Scott Chinese exclusion act a shadow of those cordons or dead lines that were established by God's chosen people to keep out the heathen and their abominable diseases, filth and immorality from the land of Canaan.

In support of the view I take I may be permitted to quote here from the annual address before the British Medical Association, at Brighton, by John Erickson, F.R.C.S.: "The greatest advance in the medical science of our generation is the clearer and more general recognition that the power of medicine to cure disease is extremely limited; in other words, that the aim of the enlightened physician should be prevention rather than cure. The discoveries of the past two centuries have taught sanitary reformers where and how to work. It is the unselfish love of mankind and a generous sense of duty that have stimulated many of these researches that are now bearing such golden fruit, and, which, while limiting the work of the doctor and curtailing his income, make life longer and pleasanter."

Dr. Priestley Smith, the great English eye-surgeon and specialist in ophthalmology, distinguished quite recently for his elucidation of the pathology of glaucoma, observes, in his late work on *Eyesight—How to Lose It*: "The fact is, many diseases are the results of fundamental changes in the structure of the body, of the deterioration of important organs, and not merely the outcome of disordered functions, so by the time the physician is called to the rescue, it is too late. The greatest triumphs will no doubt await the endeavor to *control the causes of certain diseases*."

My subject is prophylaxis, and I want to show that prevention of plague, the avoidance of disease, the fortification of the system against malady, are means much the same as those common in the beginning of the art of healing. The late Rev. Dr. Isaac Loeser, one of the most erudite of modern rabbis, said that the hygienic regulations of Moses were what made the Jews healthy, prosperous and long-lived. He told how their mingling with the Egyptians had introduced some of the "abominations" and "curses" of the heathen—that is, the loathsome and incurable diseases. To get rid of these they had to be exercised throughout a full generation in the open air, cut off from contamination and forced to adopt a system of hygiene that has never been discounted to this day. It comprised cleanliness, exercise, good moral habits, work, and a system of recreation, sport and rest. Plenty of exercise in the open air, plain, wholesome, readily digestible and assimilative food, and the avoidance of fats and poisonous substances, positively decreed. The oyster and all of its class, worms, toads, rodents, and other animals and articles, unwholesome in the hot climate of Palestine, were prohibited. They were all eaten by the heathen and they suffered for it. Between these outside nations,

afflicted with terrible plagues, and the clean, healthy, happy Jews, there was a quarantine established that was more strictly observed than that of to-day, established for the same purpose—the exclusion of incurable and malignant diseases.

As these same plagues still affect mankind and are incurable, it is the work of wisdom to keep them out, and if this cannot be done entirely, to educate the people up to a knowledge of prevention, and to a strengthening of the system so as to ward off the enemy and resist its assaults. This, I maintain, can best be accomplished by strict attention to personal hygiene, by improved sanitation, bodily cleanliness, and ample, but not wearying, exercise. This preventive of disease is within reach of the weakest and poorest. It is recommended by the illustrious Prof. T. H. Huxley, in his remarkable article on "The Struggle for Existence," published in the *Nineteenth Century*, recently reprinted in pamphlet form and scattered broadcast throughout England. The eminent naturalist, philanthropist and statesman, Sir John Lubbock, all through his recent work on the management of the masses, entitled *The Pleasures of Life*, advises the working people to stir about and sniff the fresh air whenever they can do so, thereby adding something to the worth of living, warding off disease and keeping up the physical strength for coming labors at the forge, in the mill, shop, etc. To be added to the teachings of these great men are the dicta of many other learned doctors and laymen. Going back again to the ancients, we begin with Plato's "*Mens sana in corpore sano*," and to best secure this coveted condition, we are advised by Galen that "the best physician is he who is the best teacher of gymnastics;" by Dryden: "The wise for cure on exercise depend;" by Lord Bacon: "There are no diseases whose further development could not be prevented, or which, at the commencement, could not have been cured by bodily exercise." So it seems the ancients and moderns were alike convinced from actual observation and experience that physical exercise, and particularly that which is classed generally as gymnasia, is the best prophylaxis.

In England and the United States a fresh impetus has been given to this gymnasia-preventive by many persons outside of the medical profession. A work that has created a genuine sensation is *How to Get Strong*, by William Blaikie, and the burden of its philosophy is the inculcation of physical culture, gentle exercise in the open air, gymnasia, etc. All outdoor sports are heartily advocated, and while I know they have been productive of a great deal of good, I believe they are harmful at times, because of excesses. The sporting

men, base-ball players, rowers, runners, jumpers, turners, etc., form but a small class. Mr. Blaikie writes to teachers concerning the physical education of their pupils: "Especially impress it on the weak, the poorly-built and the over-studious, who are not good at any sport, that they are going to make very one-sided men and women, if they live that long, and get them out of doors in all weathers to lay in a store of vigor and stamina, so necessary to all who hope to ever accomplish anything in life." "What physician of experience," says Mr. Blaikie, "will not urge our women to take long walks on bright days?" He goes on to show what poor walkers American women are, generally, and how, from sheer want of gentle exercise, they suffer constantly, and try by medication to mitigate what might have been readily and pleasurably prevented. In his valuable book he advocates simple home gymnasias that can be arranged at small cost; walks in the park, when possible, and in clean highways whenever the air is pure and bracing. The testimony of the talented Dr. S. Weir Mitchell, of this city, is just as direct in favor of what I have endeavored to advocate in this paper, as the best prophylaxis. In his timely and valuable work, *Wear and Tear; or Hints for the Overworked*, he says: "All classes of men who use the brain severely, and who have also—and this is important—seasons of excessive anxiety or grave responsibility, are subject to the same form of disease; and this is why, I presume, that I, as well as others who are accustomed to encounter nervous disorders, have met with numerous instances of nervous exhaustion among merchants and manufacturers. My note-book seems to show that manufacturers and certain classes of railway officials are the most liable to suffer from neural exhaustion. Next to these come merchants in general, brokers, clergymen, lawyers, and, occasionally, doctors. Distressing cases are apt to occur, too, in the over-schooled young of both sexes.

The causes are over-taxed brain-work and worry—too much mental and no physical exercise. When the breakdown comes, we send to the eminent neurologist, and all the specialist can do is to relieve the sufferer. In three cases out of five, cure is out of the question. Again, I quote from Dr. Mitchell's work that the "wearing incessant cares of overwork, of business anxiety, and the like, produce directly diseases of the nervous system, and are also the fertile parents of dyspepsia and maladies of the heart." As a cure, he advises a change of condition; a cessation of mental and nervous strain, and exercise in the open air. This is the more important when we con-

sider that this is an age of brain activity; the exercise of the brain now being more than double that of two centuries ago, in every civilized community. It goes without saying that people want to live as long as possible, and that all men live for pleasure. There is no pleasure in suffering, and to avoid it in a great majority of cases is to use the gymnasia, and give play and development to all the muscles and organs. Very soon a robust generation will spring up, a people worthy of our land, of our liberties and our civilization. Then it will be less a wonder to hear of a centenarian and one that has spent the century of life happily—pleasantly. Besides the pleasures of life thus long drawn out and enjoyed, we may be sure that a progeny will succeed with similar longevity, leading to a constant improvement of posterity that will be the most blessed if not the most generally accepted evolution of mankind. Dr. William A. Hammond, the well-known neurologist, is a believer in healthful exercise, and declares that life is shortened frequently by ignorance of all its laws, and by wilfully disobeying the laws that are known. He thinks it may be possible to live on and on, if, at the proper time, we began and studiously renewed the vital forces that ooze out of us or are destroyed by disease. The exercise of the muscles, persistence in personal cleanliness, the maintenance of thorough sanitation, the imbibition of pure air—these are the gentle and pleasant medications that push maladies far away from us, or give us an armor on which the poisoned points of plague strike in vain and fall powerless at our feet.

I might go on quoting from and commenting upon the views of the eminent physicians of the past and present, but I think I have shown you that the duty of the hour for the physician is to practice the prevention of disease. The time is in the near future when this hygiene of the people will be the leading department in the practice of medicine, and I hope it will not be long before the Government will adopt some plan of helping the medical fraternity to enforce wholesome hygienic laws, and the people be required to keep clean and to deliver up all refuse that may engender disease; the children have equal mental and physical culture, and every person be enjoined to take as much exercise in the gymnasia and in the open air as possible.

## A STUDY OF THE MANAGEMENT OF OCCIPITO-POSTERIOR POSITIONS.

BY J. NICHOLAS MITCHELL, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

THE management of occipito-posterior cases has been the cause of much discussion.

Smellie was among the first to teach the importance of effecting a forced rotation, either by passing the hand into the vagina and grasping the occiput, or by the use of the straight forceps, in cases where the rotation was delayed.

Barnes quotes Dr. R. U. West, in the *Glasgow Medical Journal* of 1856, as procuring rotation by artificial means, using the hand, but expresses his own opinion as follows: "I am persuaded that the head often turns of its own accord, when we think that we are helping it," and quotes, in favor of this same idea, Dr. Miller as saying in the *Mechanism of Labor*, 1864: "I met with a good many cases of occipito-posterior positions in which anterior rotation was effected, but the efficiency, I believed, belonged to me and not to nature, because I labored assiduously to promote it after the manner recommended by Baudelocque and Dewees . . . . I have since experimentally allowed nature to take her course in a considerable number of cases, and *I find that the desired rotation is generally accomplished about as well without as with my assistance.*"

Barnes furthermore says: "But I cannot give more than a qualified assent to the propriety of attempting to rectify the position. It is only exceptionally useful; still more rarely is it necessary, and it is not free from danger. The head can be born very well, preserving the occipito-posterior-position throughout."

Playfair, after speaking of the different methods advocated to bring down the occiput, to flex the chin, and to rotate the occiput, says: "Although any of these methods may be adopted, a word of caution is necessary against prolonged and over-active endeavors at producing flexion or rotation, when that seems delayed. All who have watched such cases must have observed that rotation often occurs spontaneously at a very advanced period of the labor, long after the head has been pressed down for a considerable time to the very outlet of the pelvis, and when it seems to have been making fruitless endeavors to emerge; *so that a little patience will often be sufficient to overcome the difficulty.*"



Leishman says: "The fact is, however, that the head cannot, in ordinary circumstances, be rotated until it has reached that stage in the labor where nature, as a rule, spontaneously induces the rotation, so that it will often be a matter of difficulty to say what share in the movement we are to award to nature, and what we may claim as the result of our operative interference."

Parvin, after speaking of the difficulties of delivery and the danger to both mother and child in cases of delayed rotation, says: "To resist the descent of the forehead, letting the occiput alone, is the simplest, safest and surest manual means of effecting anterior rotation."

In Parvin's chapter on the management of this position we find that besides Smellie, Velpeau, Meigs, Hodge, Mattei and Tarnier all taught the use of the hand to produce either rotation of the occiput forward, or of the forehead backward.

Meigs, after advising attempts to produce flexion by drawing down the occiput with two fingers, says: "If such gentle measures will not succeed, we have the powerful resource of half the hand, which may be introduced into the vagina, and sometimes within the cervix, and which, taking the head in its palm and fingers, can place the vertex wherever it may be desirable to fix it."

This statement of Meigs, and one similar by Dr. Elias C. Price, in the November number of the *HAHNEMANNIAN MONTHLY*, page 710, are the only two I have ever seen advising the rotation of the head before it has reached the floor of the pelvis. But it should be noticed that while Meigs advised such active measures only as a last resort after the failure of milder ones, and says "sometimes within the cervix," Dr. Price advises carrying the operation to such an extreme that in his sixth rule he says: "If you think there is a malposition, try to ascertain the fact, and, if necessary, rectify it as soon as the os is sufficiently dilated to admit the hand."

To arrive at a conclusion what may be the best way to manage this position, since authorities differ so much, it will be instructive to review briefly the mechanism of the evolutions of nature.

When the head presents in the oblique diameter of the pelvis it meets usually with a sufficient amount of resistance from the soft parts to produce a moderate degree of flexion, and as the sub-occipite diameter of the child's head is three and three-quarter inches, ordinarily, it descends easily and readily through the four and three-quarters to five inches of pelvic diameter, and reaches the floor of the pelvis with increased and forced flexion. The occiput then being

the lowest part of the head in the pelvis, rotates anteriorly in accordance with the well-understood mechanism of labor, that the part which is lowest in the pelvis tends to rotate anteriorly.

Fortunately, the variations from this rule, which result in a posterior rotation of the occiput, are very rare, Uvedale West placing it at 4 per cent., while Stoltz estimates it at only 2.

When this posterior rotation does occur, the shoulders are jammed down into the pelvis, and the child doubled up partly, before the occiput can escape from the vulva, owing to the long distance through which the occiput must travel. This crowding in the pelvis, and the long diameters which present, subject the soft parts to great danger from compression, if speedy delivery be not effected, and the stretching of the perinæum is so great that even in the most favorable cases there is much risk to the child and to the perinæum and soft parts in general of the mother.

For these reasons, therefore, notwithstanding that the diameter of the outlet is large enough for the head to pass, a large proportion of such cases call for and need artificial aid in delivery.

A consideration of the different factors that together produce the usual anterior rotation will be of interest as demonstrating what causes produce a failure in this rotation, and will thereby best indicate the appropriate treatment.

As I have already said, the diameters of the child's head pass readily through the oblique diameters of the pelvis, when the head is flexed, but it is also a fact that it is possible for the head to pass through this diameter either in a semi-flexed condition, or even with the occipito-frontal diameter in relation with the pelvic diameter, the latter measuring four and three-quarter to five inches, while the former averages four and one-half inches. If, then, there should be a relaxed condition of the pelvic walls, such as is found sometimes after frequent labors, or if the child's head is smaller than the average as in premature deliveries, or if any cause or causes exist that produce a reduction of the relative diameter between the head and pelvis, the head may pass through without flexion being brought about.

Now, as we have seen that flexion is a necessity to anterior rotation of the occiput, we can readily understand that there must be a delay under such circumstances after the head has reached the floor of the pelvis, and that long-continued and strong contractions of the uterus will be needed to force the head down upon the floor of the pelvis to produce the needed flexion. If, now, the perinæum also has been torn in a former labor, and the floor of the pelvis is relaxed and does not

offer sufficient counter-pressure to the action of the uterus, or if the contractions of the uterus cease or grow weak, the occiput does not descend, but the forehead does, and thereby it tends to rotate anteriorly. In confirmation of this statement I need only recall to your recollection, Dubois's famous experiment of placing a foetus in the right occipito-posterior position in the opened uterus of a recently delivered dead woman. On the application of suitable pressure the foetus descended, rotated and passed the vulva, occiput anterior. This experiment was repeated several times, until finally the soft parts became stretched and relaxed, when the occiput rotated posteriorly. A larger foetus was then used, and it again rotated anteriorly.

As a result, then, of this study of the mechanism, we find that the three necessary factors to bring about and encourage an anterior rotation are: 1. Marked flexion. 2. Good strong labor pains. 3. A firm resistance on the part of the soft parts of the pelvis. And that in many instances, from causes already noted, all the evolutions are slow.

Whoever has attended a number of these cases must have been struck with the fact of how slowly all the evolutions are performed. So markedly slow is the first stage of labor that I have long since learned, in the absence of other causes of explanation, and even before I could diagnose certainly more than that I had a vertex presentation, to determine that it was one of this position. The causes that bring about the slow dilatation continue through the second stage, and I doubt not that many who listen to me can recall cases which they have watched until they had begun to despair of the rotation occurring and, while preparing to assist, suddenly it has occurred, and a speedy delivery has been brought about. I call particular attention to this slowness, because I think a forgetfulness of it and its cause may lead to unnecessary and too early attempts to aid, or that mistakes may be made by prescribing unnecessary and unindicated drugs for the slowly dilating os when the slowness has a mechanical cause which calls for no medicine.

It is important to note, from a study of these evolutions, that rotation does not occur until the head has reached the floor of the pelvis, and to remember that the ischial spines prevent this rotation. I think also that it is well to remember, in some cases, where, notwithstanding, a good flexion occurs, yet the occiput rotates backwards, and that it is possible that the occiput may, at the beginning of labor, present to the sacrum; that as it is impossible for it to descend in the antero-posterior diameter, a rotation may occur of the head into the

oblique diameter while the shoulders still remain in the transverse. As the shoulders would descend into the pelvis in the transverse diameter, and the head have a tendency to rotate back when relieved of the enforced partial rotation on the shoulders, it may be impossible to prevent the occiput from reaching the hollow of the sacrum.

As a result of these studies, and from the fact that rotation occurs spontaneously forward in such a large proportion of cases, and from the fact that even when it does occur posteriorly yet it is possible, in a large proportion of cases, to deliver with safety to mother and child, and from the weight of authority that teaches that though slow in evolution, yet nature can accomplish the rotation, and from my own experience in the conduct of such labors, I am unwilling to accept the teaching of those who advise early interference by operations which are not themselves free from danger to both mother and child. The difficulty of passing the hand into the vagina, already overcrowded with the foetal head, and the possibility of damage from such an overstretching, is as great and greater than from the diameter that would have to pass should the occiput rotate backward, and to attempt such a manipulation before nature has proven her inability, or before the head has reached the floor of the perinæum, is unjustifiable, since nature fails so seldom if left alone. The difficulty of producing a rotation of the body of the child with the head is also very great, and if one was to follow the direction of Dr. Price in the article already quoted, not only would it be necessary to pass the hand that much further through the pelvis, and so compress the parts that much more, but also if the shoulders should be rotated completely, just as his rule seems to teach, such extreme rotation would be accomplished of the body as would kill the child. The full understanding that flexion is the necessary thing to produce, makes it seem much more advisable to practice the pressing upwards of the forehead, as taught by Parvin and others, rather than to submit the woman to the risk of passing the hand into the vagina or the uterus.

I have seen a large number of these cases, both in my own practice and that of others, and my practice has been to advise patience, as suggested by Playfair, until patience has ceased to be a virtue, when I have pressed upon the forehead during a pain, and I have seen rotation accomplished frequently. In cases of failure by this method, I think the forceps are indicated if used as advocated by the late Dr. Wilson. He used to teach, and, as I believe, most correctly, that the forceps must be applied in this position—not to the sides of the pelvis but obliquely, and that if traction be made properly and

during a pain, taking care not to hold the forceps too tight, that the occiput would be brought down and rotation anteriorly take place.

I have, in several cases, accomplished this delivery lately by means of Simpson's axis traction-forceps, which enables the operator to pull down the occiput with less risk to the perinæum than in other kinds of forceps, where the handles have to be pushed so far back against it. From my studies and from my experience, I most emphatically urge against a too hasty determination to do anything beyond the attempts to aid nature to procure flexion. If the forceps are applied too early, and especially if they are applied to the sides of the pelvis, the occiput will, of necessity, rotate into the hollow of the sacrum; and even though they be applied in the oblique diameter, unless traction be made in such a direction as to bring down the occiput, and only during a pain, or if pains be absent, intermittently, allowing a period of rest, then will the occiput, of necessity, rotate backwards. I am in the habit of individualizing my cases in this way. If my patient is a primipara, or even though a multipara, if she have a firm and resisting perinæum and soft parts, I leave the case to nature longer, remembering Dubois's experiment; and it has been a surprise to me in many cases how suddenly the long-looked-for rotation has occurred, and how speedily labor has ended in cases where no advance had been made for a long time, and without any harm having resulted from the waiting. But if I am attending a woman who has had frequent labors in rapid succession, and especially if there is an old laceration of the perinæum, I know that nature is wanting in some of her most necessary aids; and so, in such a case, I do not wait so long, but operate by the methods already indicated. In any case where pains cease or grow weak, the indication is to apply the forceps in the manner already indicated.

If rotation occurs into the hollow of the sacrum, I think it is an indication to aid nature immediately with the forceps, since, from the doubling up of the child, the jamming of the shoulders into the pelvis, and the consequent partial emptying of the uterus with its resulting loss of expulsive power, nature is working at a disadvantage and cannot effect delivery unaided as easily, as safely, nor as quickly. The greatest care of the perinæum must be exercised in such cases, and the forceps should be removed as soon as it is possible to manipulate the occiput backwards over it.

I have been called to deliver a number of cases where the occiput was in the hollow of the sacrum, and have had such a small proportion of lacerated perineæ, and have not lost a single child that was

alive when I put on the forceps, that I feel, like Barnes, as though I could not countenance any operations of doubtful risk to the woman, since the child can be delivered with comparative ease.

I have, however, attributed such good results to the early use of the forceps, and can imagine that delay might result in such a crowding of the pelvis, as to produce great difficulty in the delivery, and even need a craniotomy to effect it. In any case where I am satisfied of the death of the fœtus, I think it good practice to perforate the head and thereby reduce the diameters before delivering, and thus avoid subjecting the mother's soft parts to unnecessary risk of injury.

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### BLEPHARITIS MARGINALIS—CASES CURED BY THE USE OF GLASSES.

BY W. P. FOWLER, M.D., ROCHESTER, N. Y.

(Read before the New York State Homœopathic Medical Society.)

INFLAMMATION of the edges of the eyelids is a condition frequently met with, and in many instances is dependent upon either scrofula or syphilis. Sometimes it makes its appearance after an attack of measles or scarlet fever, these diseases seeming to develop the latent scrofula in the system. A conjunctivitis or keratitis, accompanied by acrid lachrymation, may give rise to it, as may also stricture of the nasal duct, living in a smoky, dusty atmosphere, uncleanly habits of life, and over-use of the eyes in a dim light. There are many other causes, which I will not occupy your time by naming, but shall call especial attention to *blepharitis dependent upon errors in the refraction of the eye*.

Occasionally we meet with one of this class of cases. The cause of the trouble being frequently overlooked the treatment employed is of no permanent benefit, and the patient goes on for years, perhaps for life, uncured. I herewith report a few of these cases that have come under my care:

CASE I.—Mr. H. K., æt. 28 years, a strong, healthy man, first seen June 10, 1886. Since early childhood he had been affected with redness and inflammation of the edges of the eyelids. Any prolonged use of the eyes for reading or writing would aggravate the symptoms. He had much pain in the temples and forehead. Some able prescribers in the homœopathic school had treated him,

but with no permanent benefit. Examination revealed myopic astigmatism. Cylindrical lenses—.75 D., axis  $180^{\circ}$ , were prescribed, and worn constantly. No other treatment was given, and in four weeks the blepharitis, as well as the headache, was completely cured. More than three years have now elapsed since the glasses were first worn, and there has been no return of the difficulty.

This case illustrates the uncertainty of prescribing for diseases of the eye without making a thorough examination and diagnosis. The physicians who had treated this patient failed to discover the *cause* of the inflamed condition of the eyelids, and hence no lasting benefit was given, although remedies were carefully selected. It was a case of "homœopathy misapplied." No blame attaches to the great law of cure in such instances. The trouble depends upon eye-strain resulting from a faulty shape of the eyeball, and the only way in which relief can be obtained is by the use of lenses that so change the direction of rays of light as they enter the eye, that they are brought to a focus upon the retina. With these glasses the eyes are at rest, and the trouble ceases.

CASE II.—Mr. J. S., æt. 40 years, consulted me September 12, 1887. He had been troubled with inflammation of the eyelids for fifteen years. He complained of a feeling of dryness and heat in the eyes and eyelids. At times the lids were tender to touch. The lashes were few in number and of feeble growth, the border of the lids red and thickened, and the ocular conjunctiva hyperæmic. The patient was unable to read for any length of time without experiencing a sense of fatigue in the eyes, with blurring of the letters. On testing the eyes, hyperopic astigmatism was discovered. Glasses to correct this error were prescribed—right eye, + 1 D. c., axis  $150^{\circ}$ ; left eye, + 1 D. c., axis  $30^{\circ}$ . In two months the blepharitis had disappeared, together with all sensation of fatigue, blurring, etc. The cure was permanent.

CASE III.—Mary S., æt. 32 years, came to me January 7, 1888, complaining of severe headaches, pain in the eyes, and feeling of irritation in the lids. The trouble had lasted for three years. Being a dressmaker, she used her eyes a large part of the time in sewing, but for the past six months had suffered so much that she feared she would be obliged to give up her business. Aside from the eye and head trouble she was well. Her eyelids along the border were quite red, and the lashes of stunted growth. Fine bran-like scales were quite abundant. There was compound hyperopic astigmatism. Prescribed + 1.25 D. s.  $\bigcirc$  + .50 D. cyl., axis  $90^{\circ}$ , both eyes. Under the use of these lenses a complete cure, not only of the inflammation of the lids, but of the headache as well, was accomplished in a few weeks.

I might report a number of other cases that have been cured by the use of glasses, but will not occupy more time by so doing, as there is much sameness in the symptoms, and it would in the main be a mere repetition.

In all cases where a complete cure has been effected by correcting errors in the refraction of the eye, the difficulty has been of a mild type—simple congestion and inflammation of the lid margins, with thickening and more or less exfoliation of scales of epidermis. Where the trouble assumes the form of a pustular eczema, with ulceration, formation of crusts, etc., strict cleanliness, local treatment, and constitutional remedies are demanded. It is always advisable, though, to determine the refraction when chronic blepharitis is present, for in obstinate cases the use of glasses will often assist in the cure.

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#### A SUGGESTION IN THE PRACTICE OF ORIFICIAL SURGERY FROM AN ANATOMICAL STANDPOINT.

BY E. H. PRATT, A.M., M.D., LL.D., CHICAGO, ILL.

HILTON says, in his work upon *Rest and Pain*, that where a nerve supplies a joint surface, a branch of the same nerve supplies the muscles that move the joint, and still another branch of the same nerve supplies the integuments which cover both the muscles and the joint. As a result of this nervous connection the various parts are in close sympathy, so that in inflammation of a joint there is a spasmodic action of the muscles about it, and a hyperæsthesia of the skin. If the joint trouble has been able to telegraph its distresses through nervous connection to the muscles and the skin, the lines of communication along the same channel must also be open for any messages they might have to transmit in the opposite direction. In other language, soothing applications made to the hyperæsthetic surface, theoretically, should exercise a relaxing effect upon the contracted muscles, and a soothing effect upon the inflamed joint. This is true practically as well as theoretically. Nothing is more grateful or more efficacious in the various forms of arthritis than fomentations and the application of soothing remedies to the surface of the skin.

The same principle of nerve distribution applies also to the sympathetic system of nerves. When nature connects a varying number



of her organs into an apparatus for the performance of any of the purposes of life, she does it, not by a single nerve, but by a pencil of nerves. Take, for instance, the female sexual apparatus: the ovaries, the Fallopian tubes, the endometrium, the cervix, the vagina, the vulva, the urethra and the clitoris—each has its individual nervous supply of sympathetic filaments, and yet they all come from a common source which enables them to work in harmony. In consequence of this arrangement, an irritation which involves the terminal fibres of any one of these filaments can induce irritability in any part supplied by any other of the filaments. I mean to say that an irritable clitoris can produce too frequent micturition; can induce irritability of the hymen; can cause vaginal leucorrhœa; can set up and perpetuate a cervical or uterine stenosis or catarrh; can start a salpingitis or an ovaritis. I mean an urethral caruncle or any other form of urethral irritability can induce any one or all of the same list of troubles. I mean that an irritable hymen, or an irritable vagina, can do the same; that cervical or uterine stenosis, or cervical or corporeal endometritis; that salpingitis or ovaritis may be the starting-point of identically the same symptoms.

One must never overlook, however, this fundamental principle of orificial philosophy: that irritation of an organ starts at its mouth, and that the mouths of these various organs are the points to be attacked in placing them in proper condition. The mouth of the clitoris, figuratively speaking, is its hood; of the urethra, is its meatus; of the cervix, is the external os; of the uterus proper, is the internal os; of the ovaries and the Fallopian tubes, the uterine orifices of the Fallopian tubes.

In applying the orificial philosophy to the treatment of chronic diseases, it is proper, at the first sitting, to do very thorough, all-round work; that is, to remove all forms of irritation found at the lower openings of the body. In the female, the uterus should be first thoroughly dilated and carefully swabbed out, especially at its cornua, which give origin to the Fallopian tubes. In the cervical region, if the removal of a cicatrix, or the evacuation of cysts, or removal of polypi is needed, this should now be done. The vagina should next receive attention. If it is unduly contracted in any of its extent, as is very frequently the case in single women, especially those who are advanced in life, it should be thoroughly dilated, and any rough places upon its surface nicely smoothed with tenaculum and scissors, or with a uterine curette. Then the vulva should be carefully examined, and if the hymen or any part of it is found congested, or a

source of irritation, it should be carefully removed. The orifice of the urethra should be well searched for caruncles; ragged shreds of mucous membrane, which sometimes adorn its margin, should be smoothed away, and its orifice dilated to the calibre of the urethra, and the clitoris should be freed from any attachment of its hood. If the patient be a male, the foreskin should be removed if too long; should be well slit, and a V-shaped piece removed from its upper parts if too tight; the frænum should be severed if at all shortened; the meatus should be enlarged until no constriction is felt at this point upon the introduction of the largest-sized sounds; and the urethra should be dilated to its calibre. Last of all, regardless of sex, the last inch of the rectum should be properly smoothed and thoroughly dilated.

The suggestion which comes from an anatomical consideration of the nervous distribution to these parts is valuable mainly in the after-treatment. Before placing the patients in bed, after performing the first operation upon them as indicated above, I find it a good plan to douche the pudenda and anus for about five or ten minutes. The soothing influence of warm moisture is, by means of the nervous connections of the parts above referred to, conveyed to the deeper parts which have been attacked, and measurably lessens the amount of temporary soreness and distress which is liable to be occasioned by the work.

If without an anæsthetic the passage of a sound into the urethra of either sex, or into the uterus, is the occasion of considerable discomfort, almost immediate relief can be secured in this same manner. I remember recently inserting my finger into a rectum, with a view to ascertaining the dimensions of an irritable prostate gland. Although performing the act as carefully as possible, the mere touch of the finger upon the gland induced such extreme pain in the urethra and end of the penis, that the man groaned with agony and was compelled to pace the room in his distress. He had warned me that this would be the case, and so I was unusually careful. Recalling at once the suggestion of Hilton as to nerve distribution, I decided to apply the principle in this case as a fair test. Asking the gentleman to remain standing for a moment, with his penis held over a bowl, I douched the glans with tepid water. To my extreme gratification, realizing at once how valuable the suggestion was, if carried to its possibilities in other varieties of troubles, as well as in this, I was thrilled with delight to find that the man was entirely freed from his extreme suffering in less than thirty seconds. It is now my

invariable custom, after passing a sound through the male urethra, to hold the penis in warm water for two or three minutes immediately thereafter. I believe that this simple measure has largely diminished the amount of suffering which sometimes unavoidably follows the application of the present official methods, and deserves the careful consideration of those practicing official surgery. If warm applications to the point of the penis can relieve irritation and congestion of the prostate gland, soothing applications to the clitoris and the rest of the pudenda, and better still, a stream of warm water directed through a speculum against the end of the cervix ought to exercise a like beneficial action upon irritations, congestions, inflammations of the endometrium, Fallopian tubes, and ovaries.

I would like to suggest the application of this principle still a little farther, and ask the obstetricians to try, if other measures fail, to see if they cannot relieve the rigidity of the internal os which so commonly obstructs the first stage of labor, by the application of fomentations of plain hot water to the breasts and vulva. I know that very bad cases of cracked nipples can be cured in an incredibly short space of time by a single intra-uterine douche. I believe that breast troubles, such as cancer, caking of the breasts, mastitis, etc., except when resulting from direct injury, are simply metastatic forms of uterine disorders. As my entire professional work is confined to the chronically sick, I have no obstetrical practice in which to test the value of the suggestion; but the principle upon which it is based is so generally true and reliable in other conditions, that I feel justified in prophesying that it will be applicable here. If thorough relaxation of the uterine fibres of the internal os can be secured and maintained, it will lessen materially the percentage of lacerations of the cervix, and will thus be the means of dispensing with the repair of such cases.

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## THE APPLICATION AND CARE OF PESSARIES.

BY B. F. BETTS, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

It will be admitted by all who have used vaginal pessaries extensively in the treatment of uterine displacements, that in order to get good results, much more skill is required in their application and

subsequent care, than would be deemed requisite from a perusal of standard works on gynæcology. With but a limited experience, the physician is soon convinced, 1st, that there are numerous pathological conditions affecting the pelvic organs which preclude the employment of this form of treatment; and that, 2d, there are other conditions of disease which require to be cured before pessaries can be applied to advantage.

Of the former class, we have malignant and non-malignant growths. Of the latter are all cases of inflammation of the vaginal, cervical, uterine or para-uterine tissues. The effect of injuries to the parturient passage must receive careful attention. Curreting has often to be resorted to in order to diminish the tendency to metrostaxis and profuse leucorrhœa. Incising a V-shaped piece from the cervix, or partial amputation, may be necessary to diminish the size of the organ, whilst the surgical repair of a laceration may be necessary to accomplish the same results in other cases. Some diseases of the uterine appendages prevent us from obtaining benefits from a pessary which might otherwise be expected.

In many instances, physicians become discouraged from experience with pessaries, and discard them entirely; but success will crown the efforts of those who bear in mind the fact, that the nearer the pelvic structures can be brought to the standard of health before a pessary is introduced, the more satisfactory will be its employment in every instance. The question first to claim attention is not what pessary to employ, but the more important question: "Have we a case suitable for a pessary?"

Whilst thus emphasizing the importance of preliminary treatment before the introduction of a permanent support to the uterus, I wish at this time to allude more particularly to the application and subsequent care of the instrument.

An ordinary vaginal pessary may be conveniently divided into an anterior and posterior portion; the middle curve of the instrument separates these two parts from each other. Taken together, they, of course, constitute the length of the pessary. This has to conform to the length of the vagina as measured by placing the patient in Sims's position, after the uterus has been replaced, and marking upon the examining finger, or a staff whose end is guarded by a small wad of cotton, the distance from the point of contact of the cotton wad placed back of the cervix in the posterior vaginal fornix, to the depression on the anterior wall of the vagina back of the symphysis pubis.

We next take the measurements of the upper part of the vagina into which we desire to fit the posterior part of the pessary. With the finger we must judge of the width and height of this portion, and in the same way measure the outer or anterior half of the vagina from the point where the lowest part of the pessary will rest upon the pelvic floor, to the depression on the anterior vaginal wall back of the symphysis. We have now to consider the fact that the pessary can exert an influence upon the position of the fundus in two ways. If the axis of the uterus is not bent by a flexion of the body, it may be retained in position by exerting an influence upon the vaginal walls at their point of attachment with the cervical portion. When the anterior wall is drawn tight by the instrument in front, and the posterior wall stretched in the same way, this portion of the uterus is tethered to firm supports anteriorly and posteriorly. Another influence can be exerted by the pessary coming in direct contact with the fundus in case of flexion, by narrowing the posterior part of the instrument in order that it may reach to a higher point in the pelvis. It is upon this principle that Thomas's retroflexion pessary has been constructed. For retroversion and prolapsus, when the vaginal outlet is in its normal condition, and the lumen of the vagina diminishes in diameter from the cervical portion to the vulva, Smith's modification of the old Hodge pessary is the best form to use; but there are cases in which, from injuries sustained at parturition, the vaginal outlet is too large to retain such an instrument. We can then employ a pessary with the outer portion quite angular and wide, so that the point of the lateral bars will rest upon the posterior aspect of the rami of the pubes. In some cases, a high and narrow posterior bar will keep a pessary from slipping out of the vagina by direct engagement against the posterior part of the fundus.

When a pessary rotates, after having been worn a few days, it is because the size selected was too small. In some cases, especially in the unmarried, the vulvar outlet will not permit of the introduction of a pessary large enough to be retained in its proper position. It is then necessary to have the patient anæsthetized, and to stretch the vulva and perinæum in order to permit of the passage of the proper instrument.

Whilst cases of forward displacement are not accompanied by formidable pelvic distress, they are often the cause of considerable nervous disturbance and vesical irritation; yet many eminent gynecologists pay but little attention to these displacements. When it is

necessary to rectify the malposition, an operation under anæsthesia may have to be resorted to. Especially is this the case when we have to treat a uterus that has been anteflexed for a long time, so that the cervical portion has been imperfectly nourished, and atrophy with contraction have resulted. The operation consists in the separation of the walls of the cervical canal by means of a powerful cervical dilator. In other cases it is only necessary to straighten the organ two or three times during the inter-menstrual period, and have the patient wear a properly-shaped anteversion pessary in the interim.

In cases of acquired anteflexion the latter treatment will often prove efficient. For the congenital form, the former method, by divulsion of the cervix, will be required. When it is necessary to effect replacement by merely straightening the fundus upon the cervix before adjusting the pessary, Molesworth's adjuster will serve a very good purpose. The fundus should be thrown back and retained in this position by the instrument for a few minutes, until the circulation of blood is re-established in the constricted cervical portion. But I am satisfied that the benefits derived from this replacement are not confined to the improvement in the nutrition of the cervical portion alone, but arise also from a free escape of secretions, which is permitted by the straightening of the canal of the uterus, so that the cavity becomes more nearly aseptic, and as a result, the uterine mucous membrane becomes more healthy, so that catarrhal congestion and increased uterine weight, as factors of disease, are eliminated. The above remarks apply as well to the treatment of retroflexion as to anteflexion.

After the introduction of a pessary, an examination should be made at the expiration of the first week, or, if there has been considerable tenderness, or there is any doubt about the perfect replacement of the organ, it should be made sooner. No woman should pass from the care of her physician without having been informed of the presence of the instrument, nor without having been instructed how to remove it. Vaginal douches should be frequently administered during the continuous use of pessaries. After the replacement of the uterus and the adjustment of a pessary, a woman should be as careful as she would be after the reduction of a luxation and the adjustment of a splint, until she ascertains that she is suffering no inconvenience from the use of the instrument in the vagina. Under such conditions it may be worn through the first menstrual period, after which it had best be removed and an opportunity afforded for

the parts to sustain the uterus in its new but normal position unaided ; or the application of the pessary may be supplemented by pledgets of cotton introduced into the vagina, to be removed at the expiration of forty-eight hours. In this way it is best to test the retaining power of the uterine supports until we are sure either of their efficiency or inefficiency.

Pessaries should not be worn continuously, nor can they be dispensed with abruptly.

The benefits to be derived from their use during the early months of pregnancy are even more important than at other times. For by their aid we are enabled to remove much of the discomfort experienced from gastric and other disturbances arising from uterine displacement. The same rules should govern us in their application and subsequent care as apply to their use in other cases. After parturition, when there is a tendency for the return of former uterine deviations which existed previous to impregnation, they are contraindicated until uterine involution is effected and the lochial discharge has ceased. Until then we are obliged to restrict our mechanical treatment to manual replacement alone. But the opportunity to cure the case should be made available. When pessaries can be worn, the results obtained after parturition are even more favorable than at any other time, for this is the best opportunity to cure many forms of uterine disease.

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### SYMPTOMS SUGGESTING NUX VOMICA.

BY JOS. C. GUERNSEY, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

ALAS, poor Nux ! what a much abused, overworked, yet withal frequently neglected remedy thou art ! How rashly and specifically thou art administered to the patient complaining of constipation ; to the sufferer from sick stomach ; to the man who is experiencing the bad effects of a carouse ; to the woman who is so dizzy ; to the child with foul breath and coated tongue. Nux vomica is a polychrest having an uncommonly wide range of action and yet it is too often narrowed down by us to a very limited and empirical line of duty. It is most frequently thought of for the above set of

symptoms, hastily prescribed, and then the good doctor settles himself down with the happy consciousness of duty done, and thinks: "I wish every remedy was as easily found."

What a mistake! Constipation is not easy to prescribe for, neither is nausea, neither are the ill-effects of a debauch readily removed.

It is my desire to call attention to something of the curative range of *nux vomica*, hoping that it may induce us to be more careful and more painstaking in our selection or rejection of the drug. To begin with, every patient should be questioned as to his ailment literally from head to foot, and from the inside to the outside.

The first, *i.e.*, the most valuable and most reliable indications suggesting *nux*, are found in the mental condition. Hahnemann taught, and experience proves, that the mental symptoms lead the way in deciding upon a remedy. The mental state we find to be morose and sullen, with the desire to lie down and keep still; no wish to speak or be spoken to; if an answer is given, it is rendered in a surly manner and ungracious words; though inclined and preferring to be quiet and sullen, yet is very irritable and easily aroused, when a torrent of scolding abuse pours forth; total loss of energy; and all work, even the lightest, irksome to the last degree. If a fellow who has been on a "racket" exhibits the above mental state, *nux* is *suggested* as a remedy; but we must go still further into his condition to see if it is *the* remedy. But, if he seems very sorry for his misdoing, and cries and laments a good deal over it, *nux* is not suggestive to us in so marked a degree.

*Nux* is often the first drug thought of for constipation, and, indeed, it is a most efficacious remedy. But it is of nearly if not quite equal importance in dysentery, as the symptoms show stools composed of thin, bloody mucus; small, ineffectual and most painful urging before stool; violent tenesmus during stool, etc. Hundreds, and no doubt thousands, of times *mercurius* has been mischievously given by the pathologist prescribing for the name "dysentery," where the individualizer correctly prescribing for the "symptoms" has given *nux*, and has thus wrought "the perfection of a cure."\* All perfect cures are accomplished by proceeding "upon principles that are at once plain and intelligible," to wit: prescribing not for the name

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\* The perfection of a cure consists in restoring health in a prompt, mild and permanent manner; in removing and annihilating disease by the shortest, safest and most certain means, upon principles that are at once plain and intelligible.—*Hahn. Organon*, § 2.



of a disease, but for its symptoms, always paying full regard to the proper dietetics and hygienes.

Nor must we forget *nux* in diarrhœa. In that indispensable monograph, "Bell on Diarrhœa" we read, "*Nux* must not be overlooked in the treatment of diarrhœa because more often used for constipation." Thin, watery, and genuine diarrhœic stools are abundant in the symptomatology of *nux*; and when we find them caused by over-eating, or indigestion, with the concomitants of no appetite, a feeling after each stool as though more remained in the rectum, the surly mental state, etc., we may look hopefully to *nux*.

And yet again we find our friend *nux* indicated in cases of constipation alternating with diarrhœa. A few other remedies present this condition, as antim. crud., argent. nit., sulph., etc., but none have it more characteristically than *nux*. Since then we find symptoms suggestive of *nux* in the whole range of bowel affections, let us be careful and not think of it only for constipation, to the exclusion of dysentery and diarrhœa.

Nausea and vomiting are suggestive of *nux*, but they are of a different kind from any other remedy, and must not be prescribed for empirically. *Ipecacuanha* presents some similarity to *nux* in these gastric symptoms, as in neither drug can the patient "get through" vomiting. He will say, "I get no relief from vomiting." There is difference, however.

*Ipecac.*—Nausea; constant nausea, and no relief from vomiting, because the "nauseous feeling" or "sick stomach" still remains; one may vomit repeatedly, quarts at a time, but the desire to vomit remains. Also, under *ipecac.*, there is with the nausea much accumulation of saliva in the mouth, empty gagging and eructations.

*Nux Vom.*—Nausea, with constant desire to vomit, and sensation as though relief would come if one could vomit; or a feeling after vomiting as though some unexpelled substance still lodged in the stomach or throat.

The nausea of *nux* comes *immediately* after eating; this occurs at any time of the day, though more frequently in the morning, as when one's breakfast always produces nausea, and usually vomiting, too. Nausea, with sweat, with qualmishness, or sick feeling about the heart and all over the body; vomiting, which tastes sour and smells sour; anything eaten produces nausea and a desire to vomit; also, nausea is so strongly caused when even trying to eat as to destroy the power to eat. Patients say: "Oh doctor! I wish I could eat something without becoming so deathly sick at my stomach."

Antim. crud., antim. tart., arsenicum, bryon., ipecac., nux vom., phos., puls., verat., and a host of remedies have symptoms of nausea, and nausea and vomiting, very strongly marked, and each remedy shows its own sphere of action by eminently characteristic symptoms which differ from those of every other drug, *e.g.*, some remedies have nausea up in the throat, as cyclam., phos. ac., stannum, etc.; rhus tox. has nausea in the chest; bryon., puls., etc., have nausea in the belly. Nux vom. is merely suggested to our minds by the symptom of nausea, but we must not administer nux until we have carefully sifted and singled it out as *the similitum*.

A symptom which may occur in any ailment, strongly suggestive of nux, is *heat, with red face and aversion to uncovering*. Generally, when any one is too warm, he desires to uncover. Not so here; though hot, the desire is to remain covered. It would be wrong to prescribe nux for this symptom alone, or for any other single symptom. The use of characteristic or key-note symptoms has been much misunderstood and abused. It was never intended to teach the administration of a remedy on account of the presence of one or two eminently characteristic or key-note symptoms. The true use of key-notes, and a very great use it is, is the aid they lend in simplifying the making of a prescription; they quickly suggest to us a few remedies we should study up, among which we shall probably find the *similitum*.

In headache, nux is suggested when the pain is caused or aggravated by mental exertion; from drinking wine or coffee; when accompanied by nausea and vomiting from over-feeding, occurring early in the morning; congestion, with burning and great heat and redness, and bloated face; this condition often occurring in persons afflicted with hæmorrhoids. A nux headache is relieved by wrapping the head up warmly, remaining in a warm room and keeping perfectly still. Nux is strongly suggested for noise in the ears, as of a tingling, hissing, ringing, roaring, humming. Also, there is much intolerance of, and aggravation from, any external noise or sound.

The employment of nux is suggested for patients who are completely without appetite and eat nothing; and it is equally suggested for people of inordinate appetites who injure themselves by over-eating. The tongue is heavily coated; taste is sour, bitter, putrid. There is great hunger, but no appetite; in fact, an aversion to food, and the sight or taste of food instantly nauseates. There is great thirst, too, but water is repulsive.

We are inclined to think strongly of nux in renal colic—pain

running from right kidney, extending to the genitals and right leg ; painful and ineffectual desire to urinate ; urine comes in drops, with burning and tearing pain at neck of bladder and in urethra. Doubtless, cantharis, cannabis and other remedies have been repeatedly given for these symptoms when a little nux would have wrought "a perfect cure." It is worth while to here notice that Hahnemann claims "a copious flow of urine" and "discharge of loose fæces" to be curative effects of nux. (Symptom. Cod., p. 388.) Also urine with red brick-dust sediment.

In the female sexual organs, nux should often be thought of. It has profuse uterine hæmorrhage—metrorrhagia ; prolapsus and proidentia ; menstruation too early ; abundant leucorrhœa, yellow and foetid, excoriating ; fainting during labor, after each pain.

In fact, nux vomica is such a far-reaching and comprehensive drug that it is difficult, if not impossible, to tell where it is limited.\*

We may think of it in almost every case we meet, *especially* in those coming to us from our friends the enemy—the old school. It is, too, a most powerfully acting drug, and does not need to be pushed or given in repeated doses. A very few doses, if not a single dose, will start its good work, and we may often stand aside and watch the progress to recovery.

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## SILICEA BIOCHEMICALLY, PHYSIOLOGICALLY AND CLINICALLY CONSIDERED.

BY DR. MOSSA, STUTTGART.

(Translated by S. Lillenthal, M.D., San Francisco, Cal.)

[THE paper opens with a short review of the chemical relations of silica in the animal economy, after which the author proceeds as follows:]

Hahnemann's provings revealed its manifold action on the skin. In relation to the sensibility of the skin we read : Great irritability and sensitiveness of the skin to touch ; prurigo, especially on occipital part of the scalp, behind the *alæ nasi*, in the eyebrows and

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\* In this paper I have not even thought of giving anything like its whole curative range in any one department or section. I have merely tried to call to mind how often we could use it.

whiskers, and on the back, buttocks, shoulders and lower limbs. The prover described the eruption as creeping over the whole body; soreness sets in when scratching the scalp; stitches here and there in the skin, or burning in back and legs when walking in the fresh air; itching papules on the scalp, forehead and nose, in the eyebrows, on the upper lip; very painful papules at the edge of the red border of the lower lip, and on the chin and neck; papules having a red base on the chest, thighs and back; itching miliary eruption on the calves; red spots of the size of lentils, with papules on chest, thighs and back, with but little itching; knobby elevations on the scalp; itching nodes on head and neck; hard nodes, of the size of peas, on a red base, burning itching on the right forearm; vesicles on the upper lip, with sticking or smarting on touch; varicella-like eruption over whole body after preceding itching; a corroding blister, which itches terribly, on left index finger and at the heel; panaritium and ulcerating nails; warts on arms; swellings on the right side of the neck, legs and feet, especially in the morning after rising, very tense when walking; left foot swollen up to the malleolus; foot swollen and red, leaving a white spot from pressure of the finger, with pain in the toes, extending to the malleolus.

Silicea acts on the perspiratory function as is shown by the following symptoms: Evening sweat on the head; sweaty skin even from moderate exercise (probably from weakness); copious night-sweats, of an acid odor; copious sweat at the soles of the feet and between the toes, so that these parts fester and feel sore; foul perspiration of great putridity, or excessively acid odor, though the feet do not sweat; scurfy ulcerations behind the ears, at the edges of the lips and on the scalp.

Though the hair contains silicea, we read in its symptomatology only of evening sweat in the hair, a chilly sensation about the scalp, and alopecia.

Silicea has a marked action on the glands, as is shown by the following: Painful swelling of the left submaxillary gland, sensitive to the touch, with toothache and stitches in the glands of the neck; hard swelling of the glands beneath the ear, painful to motion and touch; drawing pains in the axillary gland.

*Connective-Tissue Inflammations.*—During spring and fall the connective tissue of the limbs often swells. In children, on account of the greater plasticity of the blood, we meet rather an exudation, known under the name of *induratio telæ celluloseæ*. In adults, we meet sometimes a suppuration of the cellular tissue, spreading rap-

idly, with typhoid-like fever and fatal issue. In such a case, where the disease attacked the right forearm, *silicea* 30 cured the case in three weeks.

A brunette of twenty-five years had a gnawing, painful swelling at the corner of her right eye, very sensitive to the touch, apparently under the skin, which was inflamed all around. From the eye the swelling extended to the forehead and nose, and there were great pains in the knees and feet, which were swollen. *Silicea* 30, three doses, removed all pains in a few days.

A woman of forty years, suffering from weak eyes, complained daily about noon of severe burning in her right eye, with lachrymation, which latter caused a corroding sensation on her cheek; conjunctiva was injected, and the lachrymal duct swollen and sensitive to the touch. In the morning mucous agglutination; *mercurius* 6 and *arsenicum* 6 were prescribed without relief. The swelling of the lachrymal duct increased; the skin over it became red and shining; the swelling pulsated; the pains were worse in the evening. *Silicea* 6, in solution, soon reduced the pain and the swelling, and, though suppuration had threatened, the remedy showed its great power of producing absorption and regulating the circulation in the affected tissue. It also acts equally well where absorption is already impossible, producing good and laudable suppuration, and a healthy cicatrization by the formation of new connective-tissue.

*Silicea* has this power in many cases of carbuncles and furuncles. An old woman of sixty years had a carbuncle on her neck treated with poultices. After the first week the blisters opened, and the small holes soon enlarged into corroding ulcers; the integuments around the swelling remained hard, livid; the ichor destroyed all the cellular tissue and even the muscles, so that the processus spinosus of the fourth cervical vertebra could be felt. Great debility and emaciation; restless nights; no appetite; sallow complexion; filiform pulse. *Silicea* 30 was prescribed, and a dry bandage applied. The patient improved steadily, the ichor soon changed into laudable pus, healthy granulation set in, and in three weeks she was well again.

*Silicea* is capable of curing many forms of panaritium in which the use of the knife seemed inevitable. It is useful whether the inflammation arises from the matrix, the connective tissue, the fasciæ, or the periosteum of the phalanges of the fingers and toes. Thus, a boy of fourteen years suffered from a panaritium on the left index finger; the distal phalanx was swollen and red; pus appeared at the

anterior edge of the nail; there were tearing pains, with nightly exacerbations, in the fingers. Silicea 2 removed the entire condition in a few days.—*Hygea*, 15, 189.

An old man suffered from inflammation of the left thumb. After poulticing, the abscess broke, but the pus was not laudable, and the pains did not cease. After the third week he received silicea 30, and the finger was soon well again. Gruzewski published a very interesting case of a far-advanced case of a panaritium invading the periosteum of the middle finger, where amputation had been proposed, and in which he prescribed silicea 30 while cicatrizatio was progressing. He wanted to convince himself that all the benefit could be ascribed to silicea, so he stopped it, and gave daily a dose of saccharum lactis, but the granulations, which were then nicely advancing, ceased to grow and degenerated, and the wound discharged now a watery fluid, so that after six days a foul ichorous discharge was observed. Silicea was then renewed, and with its administration immediate improvement of the finger began, showing that this remedy is able to save a finger, though the periosteum is attacked.

It acts equally well in fistulæ, whether emanating from follicular or lymphatic glands, or from mucous membranes. Thus, Lobethal (*Allgemeine Hom. Zeitung*, 13, 245) says: "Silicea, in malignant scrofulous ulcers and fistulæ of the lymphatic cervical glands, even when associated with caries of the clavicle, discharging foul, caseous detritus, a dose daily, then every other day, or at longer intervals, soon changes the whole aspect of the case." He relates the case of a man aged forty, who, in his youth, had tinea and swollen cervical glands, and had a perfect string of inflamed cervical glands full of fistulæ, discharging foul pus for two years. So far all treatment failed. He gave from December to February six doses of calcarea carb., 24 and 30, and the glands slightly diminished. The patient was obliged to leave home for several weeks. The glands, on his return, were no longer swollen, but there still remained two fistulous openings, which discharged much fluid. Silicea 24 was given. After four weeks one opening, and shortly afterwards the other, closed. No relapse had taken place after a year.

That it is not the higher potencies which cure we see from the following case: A girl of eight years had for months a scrofulous ulcer on the neck from a suppurating gland. Silicea 30 did not do her much good. Griesselich then ordered six doses of silicea spiritus, every four days a dose, one drop on sugar. After having taken three doses, the ulcer was healed.—*Hygea*, 3, 17.

*Fistula Lachrymalis*.—A girl of eighteen years, with fistula lachrymalis after dacryocystitis, and three months' failure of treatment, was cured by Payl with silicea 6.—*Neue. Zeitschr.*, 14, 125.

*Fistula Ani*.—A child of two and a half years, with fistula in ano, was cured by two doses of silicea in three weeks. A blonde gentleman, who had the itch and a gonorrhœa suppressed, suffered from a rectal abscess, which was lanced. A fistula in ano followed, with debility, emaciation, cough and fever. China failed; sulphur did something, for after a week he felt better, and the pus looked healthier. Silicea, three doses, at intervals of one week, completed the cure.

*Affections of Bones*.—Schüssler limits the action of silicea, in relation to bones, to suppurations arising in the connective-tissue, as the periosteum.

Gauwerky says, in the *Allgemeine Hom. Zeitung*, 39, 68: "The sequelæ of caries from the earlier days of my practice show that when the right remedy is chosen, it should be continued at long intervals, for years, until the cure is accomplished. In later years I thought to hasten the cure of caries by larger and more frequently-repeated doses. I prescribed *tnct. silic. fortis* in drops; I gave silicea 3d, 12th or 30th every day or once a week; I gave silicea 200, dissolved in six ounces of water, by teaspoonfuls daily for a long time, and I did not succeed; new symptoms always developed which retarded the healing of the caries, and I returned to my earlier method; gave one dose of silicea 30 every fortieth or fiftieth day, and found that the caries was most safely healed by such sure, but slow, treatment."

Among other cases he mentions one of a young man of eighteen years, whose itch was suppressed, and who, in his sixteenth year, began to suffer from caries of his left foot, and amputation was performed. After six months the same disease set in in the elbow, and after nine months the present state was detected. Elbow and wrist of the right side were swollen, red, hot, shining, full of fistulæ leading to the joints, and discharging foul ichor; the bones were bare, and felt rough to the probe; stitching, drawing pains day and night, worse from touch or motion; hectic fever, with colliquative sweats. The first dose of silicea 30 removed all pains; for three years the patient received, every fortieth day, one dose of silicea 30, so, though the arm remained stiff, he was well otherwise. A girl of thirteen years suffered from her infancy with scrofulous and atrophic troubles. For eight years some of her bones inflamed and suppurated. She was of a delicate constitution. She complained at that

time of occipital headache; dull pressure over the eyes, and pustular eruption on upper lip; appetite, digestion and stool normal; tearing in extremities, especially in thighs; the right arm stiff in the joint, showing a shining, deep, bony cicatrix. In the left hollow of the knee there was a thick scabby eruption, corroding, spreading, exuding an acrid ichor; the left big toe was stiff in the joint, and full of crusty scabs. On the upper part of this toe and corresponding metatarsal bone, were some small fistulous openings, where the probe shows the bone denuded of its periosteum and discharging a watery fluid. The volume of the diseased parts greatly increased; foul axillary sweat; sleep interrupted by frightful dreams; a kind of somnambulism. This was on January 31st. Silicea 30 was administered, followed by another dose ten days later. Great improvement—quiet sleep resulted; the patient looked and felt better; some of the openings closed; scabs about the knee had disappeared. On March 27th some aggravation followed a journey. Sulphur 30 was given with benefit. The amelioration ceasing, silicea 30 was repeated. On September 28th the patient was discharged well.—*Hygea*, 3, 374.

A boy of three years had had caries of the mandibula for nine months; several teeth and splinters of bone had been removed; resection of the lower jaw was recommended. Kirsch found, January 13th, thin caries and general scrofulosis. Silicea 30 was given in suitable alternation with silicea 100 and 200, and in four months the child was well.—*Allgemeine Hom. Zeitung*, 46, 198.

Schindler reports the case of a woman suffering from caries of the mandibula, suppurating freely. After taking silicea, a large piece of bone exfoliated, followed by closure of the fistulæ and rapid cure.—*S. Beitræge*, 1, 148.

Chargé reports the case of a boy who, in his sixth year, complained of pain in the lumbar region, followed by curvature inwards of the lumbar vertebræ. Three years later this was treated by cauterization. After two years an abscess followed, which, after opening, discharged copiously, followed by formation of fistulæ and exfoliation of bone splinters; pus was observed in fæcal discharges. Two months ago, at both sides of the painful lumbar vertebræ, a fluctuating tumor formed, attended with hectic fever and dry cough. Silicea 24, in water, a tablespoonful daily, was ordered. Improvement began shortly, and progressed to a perfect recovery one year later.—*Allgemeine Hom. Zeitung*, 18, 77.

It is still doubtful whether silicea will help in purulent accumula-



tions from gravity, emanating from a caries in a bone lying higher up. It acts more favorably when the swelling takes place in the neighborhood of the carious process. The inflammation which, at the place of caries, is ulcerative and destructive, appears in the surrounding soft parts as an exudative process. Not only periosteum, ligaments and aponeuroses, but also the cellular tissue becomes chronically inflamed in the neighborhood of carious bones, so that it appears cartilaginous, indurated and swollen. Grauvogl describes such a case: A pale, poor boy of fourteen years had the metacarpal bones of his right hand changed into oval tuberos masses, and immovable already for six months. On some places ulceration had taken place, and the probe demonstrated the roughness of the bones. He was full of pain, mentally depressed, and, though amputation was *lega artis* indicated, Grauvogl gave silicea 6, five drops every two hours, and in a week the superficial ulcers began to heal, and after a little more than a month the hand was able to be moved, and the boy's health greatly improved. We know, says he, that of all the constituent parts of the bone, only silicea is absent in cartilage, and silicea was therefore prescribed as a nutrition remedy. Though he may have received some in his food, his organism failed to assimilate it, and it needed Hahnemann's potentiation, so that the tongue and the mucous membrane of the mouth might absorb it and carry it into the circulation. Silicea cures enchondroma as well as exostoses. In relation to the constituent parts of a carious bone, it may be remarked that there always is a diminution of the phosphate of lime, while magnesia phos., calcarea chlor. and natrum carbonicum show no great changes from the normal condition in fresh carious bones.

A girl of twenty-two years had, on the left upper arm, a round, hard, movable, painful swelling of the size of a goose-egg. Clematis softened the lower part, but the upper part yielded only to two doses of spir. silic.—*Hygea*, 9, 20.

This was probably a fibro-plastic connective-tissue swelling. Lobethal cured a cutaneous cancer on the face of an old woman with silicea 30 internally, and unguentum silicea externally.

(To be continued).

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WHICH IS THE REGULAR SCHOOL?—This question has been given a decisive answer by Dr. S. E. Chapman, of Watsonville, Cal. (*Medical Advance*, Dec. 1889), who wrote to twenty different physicians, ten homœopathic and ten allopathic, describing a case for which he sought relief, and asking for information concerning the proper treatment to pursue. From the allopathic physicians, ten widely different prescriptions were received. The ten homœopathic physicians all answered the same; they advised lycopodium.

## EDITORIAL.

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### A PROPHET AND HIS EXCLUSIVE DOGMA.

THERE have lately been published two addresses by H. C. Wood, M.D., LL.D. (Yale). The first of these is a pamphlet reprint from the *New England and Yale Review* for August, 1889, and entitled "The Medical Profession; Medical Sects; The Law." The second, of more recent date, is an introductory address delivered before the students of the University of Pennsylvania, and published in the *Medical and Surgical Reporter* for November 2, 1889. Its title is "Therapeutics and False Theories." These two addresses, taken in conjunction with editorials in the *Therapeutic Gazette* (of which journal Dr. Wood is editor-in-chief) for August and October, 1888, are of more than passing interest to homœopaths, and for this reason we devote space to their review.

The Yale address opens with a lengthy depreciation of the effort the speaker is about to make. That this depreciation is anything but sincere, is shown by his positive and dogmatic manner when dealing with the opinions of those who hold therapeutic doctrines different from those taught by himself, and still further by his remarks in the address before the students of the University of Pennsylvania, showing him to be proud of his Yale effort, when he promises that copies of the latter will be distributed among them some time during the winter.

The first point made by Dr. Wood, and this he conclusively proves, is the ignorance rife among the medical profession. He says that at "the recent examinations for the army board, out of thirty doctors who had been picked out from among the best graduates, and had been especially prepared for the army examination, only two reached the required standard." What does this statement imply? That out of thirty of the best allopathic graduates, for none others are permitted to be examined by the army examining board, especially prepared for the examination by instructors experienced in their knowledge of the demands of these examinations, but two were found competent. Can we say more ourselves? Does this look as if homœopathy grew beautifully less where knowledge and wisdom abounded? Or, to put it in a different form, where ignorance prevails there homœopathy prospers?

Dr. Wood makes no attempt at offering a remedy for this gross professional ignorance, although he hints delicately at the importance of establishing State medical examining boards, to be under the control of the allopathic medical profession. Is this suggestion reasonable when, as he himself admits, but one out of fifteen of the *best* allopathic graduates, *even after receiving special training*, is proven competent by the army examining board. The blame for the non-adoption of laws providing for State examining boards, Dr. Wood lays to what he is pleased to call the "sects in medicine." He says:

"Indeed, at present, practitioners of medicine are divided simply into two great camps or bodies. On the one side are those physicians who are generally known as regulars, allopaths or old-school doctors; on the other side are the various sects in medicine, homœopaths, eclectics, with a miscellaneous rabble beneath them of Christian scientists, faith cure and oxygen quacks, electrical specialists, and so on, and so on. The regular profession of medicine is not a sect; it does not confess allegiance to any one dominant principle; it refuses to believe in any single definite therapeutic dogma; it strives simply, in every possible way, by the aid of science and experience, to help the sick. The sects of medicine, however, are guided, or claim to be guided, by certain fixed principles which they worship as therapeutic laws. They are, of necessity, dogmatic and exclusive; they deserve and are proud to be known by titles which savor in themselves of exclusivism. Narrow and dogmatic in adherence to alleged principles, they must perish or become absolutely dominant, according as these principles shall prove to be false or true. The code of ethics, published by the American Medical Association, is to the regular physician what the creed is to the churchman. The only binding clause which it contains restricting freedom of belief or practice says: But no one can be considered a regular practitioner, or a fit associate in consultation, whose practice is based upon exclusive dogma, the rejection of the accumulated experience of the profession, and of the aids actually furnished by anatomy, physiology, pathology and organic chemistry."

That the allopathic school is itself sectarian is plain from the above words of Dr. Wood. That the sectarianism of homœopathists is the result of allopathic bigotry is so well known as to need but a mere mention. The charge that homœopathists are dogmatic and exclusive is false. Homœopathy is a positive term, implying affirmation, and not negation. A homœopathist is one who believes in homœopathy. While being a believer in homœopathy, he is not necessarily a non-believer in other things. Thus, a man may be a homœopathist and an electro-therapeutist, or a homœopathist and a surgeon.

He affirms that he believes in homœopathy, but he does not deny that he has faith in the curative virtues of electricity or the knife; nor does he deny the palliative properties of antipyrine, morphia, sulphonal, and a host of other drugs.

Individually, we find allopathists exclusive dogmatists, and Dr. Wood is no exception to the rule, as we shall show presently in reviewing his explanations of the relation between physiological action of drugs and the diseased conditions which said drugs cure. One allopath has strong faith in purgation for everything, and scarcely, if ever, adopts any other therapeutic measure; another adopts the germ theory for his guide; another follows the doctrine of physiological antagonism, and so on. It has been said by students at a certain prominent allopathic college that they find it necessary, in order to pass their examinations in materia medica and therapeutics, to study these branches according to three different theories of drug action. One professor believed a drug cured this disease because it did this and that, and another professor thought it cured because it was capable of doing thus and so; still another professor taught nihilism in therapeutics; and the poor student had to keep himself posted on the hobbies of all three in order to gain his diploma. Is it any wonder that Dr. Wood speaks as he does of professional incompetency? As critics of each other, what successes these allopathists be!

In both addresses, Dr. Wood casts decided aspersions on Hahnemann and his doctrines. The latter he states as three in number. The first of these is the so-called psora theory, which is not now held by homœopathists in its original form. But what has arisen in its place? The doctrine that disease has a dynamic origin. This theory is held not only by homœopathists, but also by many of the leading allopathists of to-day. On this very point Dr. Wood has but recently expressed himself, if the report of his remarks is correct, to the effect that he did not believe phthisis to be hereditary *per se*, but that patients might inherit certain peculiarities of constitution which made them susceptible to the ravages of the bacillus of tuberculosis. Again, such a great thinker as Sir Andrew Clark has already expressed himself on this very subject, as follows:

“We are so much concerned with anatomical changes; we have given so much time to their evolutions, differentiations and relations; we are so much dominated with the idea that in dealing with them we are dealing with disease in itself, that we have overlooked the fundamental truth, that these anatomical changes are but sec-

ondary, and sometimes the least important, expressions or manifestations of states which underlie them. It is to these dynamic states that our inquiries and our thoughts should be turned; they precede, underlie and originate structural changes; they determine their character, course and issues; in them is the secret of disease; and if our control of it is ever to become greater and better, it is upon them that our experiments must be made."

To return to Dr. Wood.

"The second doctrine of homœopathy which still survives to some extent, inculcates, not merely that certain substances are indefinitely active in exceedingly small doses, but that a substance like chalk, which is in large doses inert, becomes under the influence of trituration and dilution possessed of intensely active properties."

By denying this, Dr. Wood commits a grave error. Many scientific men of the allopathic school admit that by reduction to fine states of sub-division, certain substances acquire new properties. This increase in medicinal power is in accordance with natural laws, and not the result of the unfolding of spiritual powers, as he would imply. Hahnemann made no claim that this power was spiritual; he used the term "spirit-like," which is an entirely different matter.

To proceed, quoting Dr. Wood:

"Remembering the number of the followers of Hahnemann, surely the bitterness of Carlyle—when he says 'where ten men are gathered together, there are nine fools'—seems justified."

There are 120,000 physicians, of whom 108,000 are allopaths, in the United States. Let our readers make a little mathematical calculation, and they will see that Dr. Wood's application of the statement of Carlyle is strictly correct.

The third fundamental doctrine of homœopathy is the law of similars—*similia similibus curantur*. Dr. Wood here admits that there is to be a partial truth, but fearing that in so doing he admits too much, he at once urges, what all have ever recognized, that Hahnemann was not the discoverer of this law.

"As illustrating the subject, let me suppose a case of vomiting. Ipecacuanha, when given in large doses, will cause vomiting, but under certain circumstances, when administered in minute quantity, it will relieve vomiting. Witnessing such triumph, the bystander cries: 'Great is *similia similibus curantur*, and Hahnemann is its prophet!' But a second case of vomiting appears, which is in-

creased by ipecacuanha and is relieved by opium, which does not vomit when given to the normal man in large doses, but makes him insusceptible to the action of emetics. Now the upholder of the doctrine of *dissimilia dissimilibus curantur* cries: 'Behold, I have the truth—the remedy which produces the opposite of the symptom is the remedy to relieve the symptom.'

In thus remarking concerning the action of opium, Dr. Wood shows himself in ignorance concerning the action of it and its alkaloïds. Any one who has used these drugs to any extent knows that vomiting is of very common occurrence following their administration; so, after all, opium does cause vomiting when given to the normal man in appreciable doses. Of course, in lethal doses, its action is as Dr. Wood states.

Now let us proceed with Dr. Wood's explanation of the two cures of vomiting above quoted. It will be noted that in both instances he brings forward an explanation based on a doctrine the same in each; and this, taken with other explanations and the principles taught by him, shows him to be a follower of an exclusive dogma, that of physiological antagonism. So thoroughly wedded is he to this doctrine or rather dogma, that he would not abandon it, though bedside experience fails to confirm it. As he says: "We have adopted the modern scientific method, and have subordinated to it, . . . bedside experience." Who now rejects the accumulated experience of the profession!

Now listen to Dr. Wood's explanation of the two cures of vomiting as quoted above, and learn the application of *his* exclusive dogma:

"Take the case of vomiting just spoken of: One man vomits because the stomach is in a condition of depression, and a stimulant like ipecacuanha relieves the vomiting by removing the cause, *i.e.*, the depression; another patient vomits from irritation of the stomach, and he is made worse by an irritant like ipecacuanha, but is relieved by a substance like opium, which is soothing and numbing."

But the addresses under review are not the only places where Dr. Wood has advanced such explanations of homœopathic cures. Let us quote from the *Therapeutic Gazette* of August 15, 1888:

". . . . A case in which a child, suffering from intestinal catarrh, recovered after being put upon minute doses of podophyllin. Supposing that the medicine had anything to do with the result, the effect would not be an exemplification of the principle advocated by Dr. Reed, but, to our thinking, was produced in an entirely different way.

After inflammatory conditions there is relaxation, so that in the latest stages of any catarrh locally stimulant medicines may be required. Certainly, podophyllin, in overdoses producing violent purgation, would not be looked upon as an intestinal sedative, but as an irritant, and if, in the case spoken of, it did good, it must have been in virtue of its acting in small doses precisely as it acts in large doses—namely, as a stimulant.”

To explain the great success with which homœopathy has met, Dr. Wood stoops to ridicule and sophistry. The old threadbare anecdote of pork and cabbage curing the shoemaker of his fever but killing the tailor, is related as a creation of the nineteenth century. The method it is intended to illustrate applies with more force to the allopathic school than to our own. The first success of homœopathy he attributes to the faulty therapeutic methods in vogue in Hahnemann's time, when, he says, the sick room was a veritable slaughter house.

The present success of homœopathy, he says, is apparent rather than real, and “that where the law requires the physician to be educated the homœopathic system withers.” This is a bald statement, without any facts to support it. It is true that in Europe homœopathy does not thrive as in this country,—but why? Not because of the physicians there being educated, but because the classes and the masses are so steeped in bigotry as to make any new therapeutic methods, or new methods in anything else for that matter, well-nigh impossible. When to this we add the almost perfect control held by the allopaths over the gateways to the medical profession, we have sufficient explanation of the poor progress of homœopathy abroad.

To return to Dr. Wood's remarks :

“It is a wonder that whilst the records of chemistry, physiology, natural history, electricity, nay, of the whole range of the sciences, are filled with the names of doctors well forward in the front rank of the famous [Yes, it is a wonder.—EDS.], that after long searching I have not been able to find one homœopathic practitioner holding even a second-rate place in science.”

To this we would say, that so far as natural history, chemistry and electricity (aside from electro-therapeutics) are concerned, men who have been famous in these branches have not amounted to much as physicians; in fact, have been failures as such; or, perhaps, after obtaining their diploma, have become so disgusted with allopathic therapeutic dogmas as to abandon the profession for some other branch of science more to their taste. There are homœopathic physicians

who, on the other hand, were not only famous as scientific men, but eminent as practitioners of medicine also. At the head of these stood that great man, Constantine Hering.

To illustrate modern therapeutic methods, Dr. Wood instances the treatment of typhoid fever. Here he places himself open to attack. These self-same methods which he so earnestly advocates have, in practice, been followed by a mortality varying from 10 to 15 per cent., while homœopathic methods, which he so heartily condemns, succeed in saving from 98 to 93 per cent. of all cases. *But then we are to subordinate bedside experience to modern scientific methods!* Let us proceed :

"If any 'ism' arise or any new system of practice having aught of plausibility be brought forward, it is at once tested in a thousand sick rooms. Jaborandi from the South American Native; pink root from the North American Indian; cotton root from the Southern negro; koso from the Abyssinian barbarian; veratrum viride from American country practitioners; hyosine from the hospitals and vivisection posts of these United States; from all quarters, from the earth and from the waters under the earth, have we garnered what we possess."

This enumeration of the sources from which allopathic remedies are obtained certainly appears sweeping enough, but our readers will notice that homœopathy is not mentioned. Later, he says :

"Whatsoever of good there has been in eclecticism, in Hahnemannism, or in bare-faced quackery,—whatsoever of knowledge could be obtained from popular beliefs,—all these have we appropriated." [Without credit.—Eds.]

In closing, Dr. Wood returns to the subject of professional ignorance. He here indulges in an outburst of eloquence which cannot be excelled and but seldom equalled.

"Yesterday the valley of the Conemaugh resounded with the roar of furnace, the clang of iron on iron, and was filled with the prattle of women and children in the homes of twenty thousand busy workers. A moment of terror, a roar of water, a wild wail, fire and flood, and the valley grew still as the valley of death. Then America, stirred to its centre, poured out its millions of money with a generosity the history of the world does not parallel. But what of the 8000 corpses cold and stiff in their mud graves? Dead, because the government had not done its duty—dead, because the government which should have protected its citizens allowed a few rich men with a dam of hay and boughs and earth to hold up 700,000,000 of tons of water 300



feet above the doomed city—a governmental crime just as peculiarly American as was the sympathetic popular outburst which followed the catastrophe. In the presence of the dead of Conemaugh the nation bows in sorrow; but before God I tell you that it is my belief, founded in the largest experience, that if the dead who in the last fifty years have been sacrificed in these United States upon the altar of professional ignorance could this day rise before us, the thousands of Conemaugh would be lost in the multitude; silently, heralded by no roar of flood, mourned by no outburst of national remorse or sorrow, one by one, they have passed over; a never-ending holocaust to governmental imbecility.”

To all of which we say “Amen!” We would add thereto that Dr. Wood and every allopathic teacher in the country has had his share in foisting the men who have been guilty of these wholesale murders on an unsuspecting public.

Ere we close let us refer to a statement made in the address before the University of Pennsylvania students.

“I remember a student I had many years ago, who complained that his family were homœopaths and were constantly tormenting him to study in that school. I said: ‘Why didn’t you, then?’ ‘Well,’ he replied, ‘I was going to, when one day I was talking to our family physician, who was, of course, a homœopath, and he pulled out of his pocket a small vial, and, holding it up, said: “When I began to practice medicine I put in that bottle one-quarter of a grain of mercury and filled it up with sugar of milk; as fast as the vial became empty I refilled it with sugar of milk, until now it is fairly alive with the spirit of healing.” That disgusted me with homœopathy, and I came here.’”

It is possible, since Dr. Wood has said so, that this story is true, but a great deal more probable that it isn’t. It is only sufficient to say that homœopathy sanctions no such arrant nonsense as that; in fact, we can hardly understand how any one short of a lunatic would make such a statement as that credited to the homœopathic doctor in question. The unreliability of Dr. Wood’s statements is shown in the following:

“The homœopath is a mediæval survival, clinging to an empiricism which he dignifies as a law, but which is at best only an old and very faulty rule of thumb, of which Prof. Charles Mohr, a far-famed homœopathist, says: ‘No rational explanation of the *modus operandi* of a cure under the so-called law has been made.’”

What Dr. Mohr did say is the following:

PHILADELPHIA, April 5, 1889.

H. C. WOOD, M.D.

DEAR DOCTOR: In reply to your favor of 2d inst., I beg leave to say that you did not quite get my meaning in our informal chat on therapeutic methods. I stated that some homœopathic physicians believed in a therapeutic *rule*, rather than in a therapeutic *law*, because no rational explanation of the *modus operandi* of a cure under the so-called law had yet been made.

My own views may be briefly stated thus: That outside its own sphere, *i.e.*, in cases requiring surgical, mechanical, chemical, dietetic or hygienic treatment, *similia* does not apply; but to that very large class of natural diseases, occurring in persons having the integrity of tissue and reactive vitality necessary to recovery, the similar remedy, *i.e.*, a drug capable of inducing in healthy man subjective and objective symptoms like those present in the disease to be treated, is universally applicable. In other words, I am a follower of Hahnemann, and believe that the homœopathic principle is a *LAW* in its own domain.

Yours truly,

C. MOHR.

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DR. S. R. DUBS.

Dr. Samuel R. Dubs died at his residence in Doylestown, Pa., December 26, 1889, in his seventy-eighth year. Dr. Dubs was a member and one of the founders of the American Institute of Homœopathy in 1844. Dr. Dubs was born in Philadelphia, November 8, 1811, and was a son of Martin and Sarah (Jones) Dubs, natives of Lebanon County, Pa., and of Swiss and Welsh descent. His father was a wholesale grocer in Philadelphia, and was among the wealthiest merchants of that city in his day. Dr. Dubs was reared in Philadelphia, and there attended school until he was seventeen years of age, when he began the study of medicine under Professor Charles D. Meigs, and in 1836 graduated from the University of Pennsylvania. He practiced in Philadelphia until 1858, when he removed to near Doylestown. In 1868 he returned to Philadelphia, and remained there until 1872, when on account of failing health he returned to Doylestown.

Dr. Dubs is the eighth senior of the American Institute to die since the session at Minnetonka.

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# GLEANINGS.

## GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

**ABSCESSES IN THE HEART DURING THE COURSE OF INFECTIOUS ENDOCARDITIS.**—Abscesses may occur in the heart during infectious endocarditis, and may be of a metastatic character, such as sometimes occur in consequence of pyæmia as found in other organs; and they may also result from the simple extension of the inflammation from the endocardium to the heart muscle. These latter may be superficial, and seated only in the endocardium and valves, or deep-seated, penetrating the myocardium. The latter are mostly situated at the aortic orifice, where it borders on the intraventricular wall. The abscesses open mostly into one of the cardiac cavities, or at least into the aortic sinus; the communication may be a direct one, so that the condition simulates a cardiac aneurism. These abscesses sometimes take on very queer shapes. They may lead through the intraventricular septum into nearly every part of the cardiac muscle. In other cases the abscess cavity is found in the centre of the muscle, separated from the endocardium by a comparatively thick layer of muscular tissue. Usually the accumulation of pus causes an encroachment on the endocardium, and gives the impression of a smooth-walled swelling of the size of a cherry or hazel-nut, containing a brownish fluid, a mixture of pus and blood, or diffuse gangrenous tissue. Bacteria are always found in the pus of cardiac abscesses.—*Allgem. Med. Centr. Zeitung*, 58, 1889.

**CHANGES IN THE DIFFERENT ORGANS FROM THE INTERNAL USE OF LEAD.**—Coen and d'Aguilolo experimented on rabbits who received daily 0.3 of acetate of lead in small doses. The kidneys were found in a state of interstitial inflammation, a glomerulitis with hyaline degeneration of the bloodvessels, and finally interstitial plastic nephritis. In the muscles there appeared at first a peculiar degeneration of the muscular fibres, not in the form of the usual fatty degeneration, but as a fine, granular, slowly-developing necrosis, accompanied by a vesicular and sometimes by a colloid degeneration of the nuclei. Then the symptoms of interstitial myositis appear, and finally a connective tissue neoplasm, taking the place of the destroyed muscular fibres. These changes are found in foci between healthy spots. In the stomach a considerable proliferation of the epithelium of the glands and of the mucous membrane sets in without any essential degenerative process; with it, also, a focal inflammation of the smaller vessels of the submucosa. This inflammatory process is met with to a greater degree in the small intestines. In the liver was found, at first, fine granular degeneration of the protoplasm of the hepatic cells, and, at a later period, interstitial connective tissue proliferation, especially around the biliary ducts. Lead acts injuriously on the specific elements of organs and causes their degeneration; then it acts on the bloodvessels, causing inflammatory foci, and finally connective tissue neoplasms.—*Centralbl. f. Klin. Med.*

**GLANDULAR FEVER.**—Pfeiffer, of Wiesbaden, calls attention to a morbid state hardly mentioned in text-books, characterized by acute chill, heat, pains all over, great restlessness, inappetency and finally vomiting, and the cause of which is unknown. Examination reveals a temperature of 40° C. or thereabout. The tongue is slightly coated, the fauces slightly reddened without coating; all the organs are normal, but around the neck, especially at the posterior edge of the sterno-cleido-mastoid and at the nape, we find numerous lymphatic glands swollen and painful to pressure and motion. Two days often suffice for a complete recovery. Sometimes the glands of one side swell, then those of the other side, the fauces become more red, coryza and cough set in. On the third or fourth day the liver and spleen are palpable, and the patient complains of pain exactly in the middle between umbilicus and symphysis. We meet, therefore, changes in the lymphatic glands around

the neck, in the liver and spleen, perhaps also affections of the mesenteric glands (pain between umbilicus and symphysis), retro-oesophageal glands (difficulty in swallowing), retro-tracheal glands (cough); the axillary and inguinal glands were never affected. Very characteristic is the painful swelling behind the sterno-cleido-mastoidens. The disease is probably of infectious origin. The question arises, is it a disease *sui generis*, or is it an aborted state of another disease, as typhoid fever, measles, scarlatina or diphtheria?

There is also met with, in children, a sub-acute affection, in which the liver, spleen and mesenteric glands are affected, and in which we find stubborn, not copious, greenish or grayish diarrhoea, moderate fever, considerable emaciation, swelling of the liver and spleen, slight albuminuria, and more or less ascites. Calomel and a Priesnitz pack around the abdomen, with a strengthening diet, act splendidly. It is a general engorgement of the abdominal glands, differing from simple intestinal catarrh and from typhus, nor can it be taken for tabes mesenterica, as health is generally fully restored.—*Centralbl. f. Klin. Med.*, 28, 1889.

**NON-TUBERCULAR HÆMOPTYSIS OF ELDERLY PERSONS.**—Sir Andrew Clark, after calling attention to a form of hæmoptysis which has thus far remained undescribed, presents the following conclusions: 1. That there occurs in elderly persons, free from all disease of the heart and lungs, a form of hæmorrhage arising out of minute structural alterations in the terminal bloodvessels of the lungs. 2. That these vascular alterations occur in persons of arthritic diathesis resembling the vascular alterations found in osteo-arthritic articulations, and are themselves probably of an arthritic nature. 3. That though sometimes reaching to a fatal issue, it usually subsides without the supervention of any coarse anatomical lesion of either heart or lungs. 4. That it is aggravated or maintained by the administration of astringents, and by indulgence in liquids to gratify the thirst caused by them. 5. That the best treatment is diet and quiet, cutting off the supply of liquids, quieting the cough, calomel and salines, alkalies and iodide of potassium, and in free counter-irritation.—*Medical Press and Circular*, October 23, 1889.

**THE ACTIVE PRINCIPLES OF CUNDURANGO.**—The bark of cundurango contains three active substances, two glycosides and a resinous substance. Cundurangin is a mixture of the glycosides, which coagulate, like albumen, when heated to 40° C., and which separates the quasi albumen when the watery solution is saturated with salt. In hot filtrated decoctions, cundurangin cannot be detected.

Cundurangin is a poison to the central nervous system. In small doses its action shows itself in a decided ataxic gait, similar to that of locomotor ataxia. In larger doses the lower extremities lose their power, and the animal is apt to fall over to one or the other side; finally, it becomes unable to walk at all. Cutaneous and tendon reflexes are increased. In still larger doses the state of irritation is followed by a paralytic state. The animals become restless and suffer from clonic convulsions. Even during the paralytic stage the reflexes are increased. The convulsions emanate from the medulla oblongata. Cundurangin acts also on the peripheral nerves and the muscles, as their electrical irritability is at first increased and then diminished. Loss of appetite and, at first, increased salivation and vomiting were constant symptoms in carnivorous animals. Glandular secretion is everywhere greater than normal. The drug does not seem to possess much action on the heart and bloodvessels; the vomiting seemed to arise from the action on the central nervous system. In carnivorous animals the fatal dose of the glycoside is 0.02 gramme per kilogramme; in animals living on grass, about three times that quantity is required. Autopsies failed to show any lesion in the central nervous system in cases of poisoning.—*Allgem. Med. Centr. Zeitung*, 76, 1889.

**LEAD POISONING FROM SILK THREAD.**—The *Sanitary News* is authority for the statement that silk thread is soaked in acetate of lead solution to increase its weight, and that those who pass it through the mouth in threading needles sometimes suffer from lead poisoning.—*College and Clinical Record*, November, 1889.

**HYSTERICAL TREMORS.**—Bitot in considering the subject of tremors, divides those of hysterical origin into three varieties: 1. Such as are of a trepidatory form. 2. Vibratory. 3. Intentional, resembling in character the tremors of disseminated sclerosis.

1. *Trepidatory tremors* are habitually localized in one extremity, especially in a lower one, and consist of rhythmical shocks of alternate extension and flexion,

going from the foot to the leg, from the leg to the hip, and thence to the pelvis. It resembles the epileptoid agitation in sclerosis of the pyramidal tracts in the spinal cord, differing from that condition only by the absence of spasmodic contracture of the muscles. They often cease entirely when the patient is in the horizontal position, and show themselves only when in the sitting or standing posture, or *vice versa*. Sometimes they last for a long time; in other cases they are rapidly cured like other hysterical symptoms. The characteristic symptoms then are: In the horizontal position, voluntary motion intact; the muscles neither contracted or atrophied; patellar reflexes normal; no epileptoid trepidation when raising the feet; but as soon as the patient rises, rapid and rhythmical involuntary twitchings set in. The gait is hesitating or hopping as in patients suffering from spasmodic tabes. Shunting the eyes increases the instability. When sitting the tremors are lessened though still very manifest.

2. *Vibratory Hysterical Tremors*.—These consist of small, short, rhythmical shocks, causing in the extremities short vibratory oscillations, especially in the arms. In many cases they show themselves best when the patient extends the arms horizontally, and cease when the arms hang down by the side of the body. They do not prevent the execution of voluntary movements, but merely cause lack of precision in delicate manipulations. They are variable in their rhythm and amplitude, and yield sometimes easily to the magnet or to electrization. Hypnotism has cured several cases. Mental emotions are frequently supposed to give rise to them. Traumatic hysteria is not so well-known as it should be, and is usually described by surgeons as reflex tremors. Toxic and dyscrasic tremors often originate in the hysterical character of the patient.

3. *Intentional hysterical tremors* are only produced by voluntary movements and cease as soon as the muscles are at rest. We meet such tremors in multiple sclerosis, in some cases of cervical hypertrophic meningitis, and in focal lesions of the cerebral hemispheres; but we may meet them also under the sole influence of hysteria, for after a wrong diagnosis and worse treatment, such cases have been entirely cured, as if by a miracle, after the application of a magnet. Westphal has published two cases which showed during life all the symptoms of cerebro-spinal multiple sclerosis, and still the autopsy failed to show any appreciable lesions in the central nervous system. It is more than probable that hysteria may also be the cause of the intentional tremors developing in the consequence of acute febrile attacks in the course of small-pox, erysipelas, and typhoid. The same may be the case in the intentional tremors observed after acute intoxications, especially if mercurial.—*Progres Med.*, 37, 1889.

**PYRODINE**.—Pyrodine is a very dangerous antithermic, reducing the temperature for twenty-four hours, which then gradually rises again, and the pulse becomes slower and harder, the urine more abundant and sometimes albuminous. Even in such small doses as 0.30 gramme it causes a progressive anæmia, which may last several weeks. When a patient takes from 0.50 gramme for two or four days, the anæmia may be accompanied by jaundice. Ranvers gave to a young girl, aged fifteen years, 0.20 of pyrodine, and there resulted a diminution of hæmoglobin to the extent of 43 per cent., of the red blood-corpuscles to 50 per cent. On the seventh day the blood contained only 35 per cent. of the normal quantity of hæmoglobin, and the red blood-corpuscles had lost their power of agglutination and forming rouleaux, passing into a process of degeneration.—*Bull. Med.*, 87, 1889.

[Might it not be desirable to institute provings of pyrodine? We cannot have too many remedies for pernicious anæmia. Pyrodine may be suitable even in some cases of leucocythæmia, when the cause is a hæmatic deterioration.—S. L.]

**THE INFLUENCE OF DILUTION ON THE ACTIVITY OF THE TUBERCULAR POISON**.—Hirschberger has demonstrated that tuberculous cows produce in more than 50 per cent. of the cases an infected milk, possessed of virulent properties. Bollinger, of Mnnich, has now studied the infectivity of that milk as sold by milkmen to their customers. It is well known that in most dairies the milk is collected from many cows, and put in a large vat, from which it is transferred to cans for distribution. Bollinger bought milk from ten different milkmen, and injected two cubic centimetres of each of the samples into as many different Guinea pigs. The animals were all killed after five or six weeks, and a negative result followed. He then took milk from tuberculous cows, and diluted the same with water, and showed that by such dilution the virulence of the poison was much diminished, or even entirely lost. *Vice versa*, he found that the continued use of infected milk is dangerous, especially

so when the supply comes from one cow. By mixing the infectious milk of a tuberculous cow with the milk of a healthy one, as is done in large dairies, the danger is greatly lessened. It is a good thing for infants that cow's milk be diluted before it is introduced into their delicate digestive organs. These experiments explode the superstition that babies ought to be fed on the milk of one cow.—*Allgem. Med. Centr. Zeitung*, 86, 1889.

**URTICARIA IN CHILDREN**—This dermatosis, so says Comby, of Paris, is a true toxæmia, nature throwing upon the skin poisonous substances elaborated in the digestive tract. Clinical experience demonstrates that this urticaria in children always bears a relation to transitory or permanent digestive disorders. It may be excited by dentition, as in some children who are attacked by it at the eruption of every tooth. Relapses are frequent; it can only be cured by careful regulation of the food. It is hardly ever met with in children who are nursed by the mother. Bottle-fed children are the most frequent sufferers, as their nurses are not only careless in cleansing their bottles, but also in the preparation of their food. As children grow up, all spices should be forbidden, as should also pork, sea-fish, lobsters, etc. Often the disease becomes chronic, lasting until adolescence, and then changes to Hebra's prurigo. Cod-liver oil externally applied may be of service in some cases for the relief of the terrible itching which often accompanies urticaria.—*Bullet. Med.*, 85, 1889.

[Comby is right; without regulating the diet all treatment must fail. We would lead the attention of the reader to *antimonium crudum* and *tartaricum*; to *arsenicum* in chronic cases, especially when caused by eating shell-fish; to *kreosotum*, *bovista* and *pulsatilla*, in cases of gastric origin; and especially to *natrum muriaticum*, as we have found such children especially fond of eating salt; candy-eaters may be benefited by *argentum nitricum*. But, above all things, regulate the diet.—S. L.]

**SOMNAL**.—Somnal or ethychloral ( $C_7H_{13}Cl_2O_3N$ ), the new hypnotic, differs from chloral urethran by the addition of two atoms of carbon and four atoms of hydrogen. It fuses at  $42^\circ$ , and is not affected by nitrate of silver or by acids. Raymond adopts the following formula for the dispensing of somnal: Somnal, 10 grammes; distilled water, 45 grammes; syrup of strawberries, 20 grammes. S. A table-spoonful at night. In about a half-hour after taking the dose sleep sets in, and continues for from six to eight hours. The drug has no unpleasant effects on digestion, pulse, respiration or temperature.—*Bull. Med.*, 85, 1889.

**SUSPENSION IN THE TREATMENT OF NERVOUS DISEASES**.—Experiments in the treatment of nervous diseases other than locomotor ataxia by suspension have been made by the physicians of the faculty of Nancy. The first sitting was usually of only a half-minute duration, although in many cases where the patient was of thin build it could be prolonged to five minutes. When the patient could carry on a conversation during the suspension it was considered that the head-gear was properly arranged. Some incidental effects of the suspension were occasionally noticed. Thus one ataxic had vertigo, and begged to be let down; another was seized with fainting; a paraplegic suffered from contractions of both upper and lower extremities, which ceased on his being let down; a very stout woman always complained of intense congestion of the face, headache, and lumbar pains, and these symptoms sometimes lasted for a whole day after the suspension. Contra-indications to suspension are anæmia, obesity, œdema, pulmonary emphysema, atheroma, and cardiac disease. The conditions in which it was tried in these experiments were tabes dorsalis, diffuse myelitis, spasmodic paraplegia, diverse neuralgiæ, traumatic neuroses, athetosis, hypochondriasis, hysteria, neurasthenia, and incontinence of urine. In tabes the results were temporarily beneficial, but none of the patients recovered the patellar tendon reflexes, and the Argyll-Robertson pupil persisted. All the patients with diffuse myelitis were benefited; but the treatment failed utterly in athetosis. In neuroses and neuralgiæ it is certainly worthy of trial, as two-thirds of these cases in which it was tried were greatly benefited by it. It failed in hypochondriasis. Suspension has relieved or entirely removed: 1. The pains in tabes, diffuse myelitis, neuralgiæ, and muscular rheumatism. 2. Anæsthesia or abnormal sensations. 3. The motor symptoms, as the ataxia in tabes; the paresis and spasmodic symptoms in spastic paralysis or hysterical contractures. 4. Paresis of the sphincters and idiopathic nocturnal enuresis. 5. General symptoms, as impotence, spermatorrhœa, nocturnal seminal emissions, and priapism. 6. Cerebral or psychical symptoms, as night terrors, fear of lightning, sensation of falling down from a height.—*Progres Med.*, 44, 1889.

**SUSPENSION IN LOCOMOTOR ATAXIA.**—Lumbroso, of Leghorn, Italy, in order to determine the physiological effects of suspension on the spinal cord, instituted some experiments on animals. Rabbits were exposed to mild and severe suspension. Some of those in which severe suspension was tried succumbed at the tenth sitting. At the autopsies he found hyperemia and small hemorrhages all through the spinal cord, especially in the cervical region. The microscope revealed slight bloody extravasations in the gray substances near the central canal, and general hyperemia throughout the entire nervous system. The rabbits submitted to mild suspension did not die, but, when killed, did not exhibit anything abnormal in the nervous centres. These results (bearing in mind the difference between human beings and rabbits, and at the same time the difference between a healthy and a morbid spinal cord) demonstrate that suspension, by causing a hyperemia of the nervous system, may favorably influence morbid processes, but they also show the danger of making the traction too strong.—*Semaine Med.*, 46, 1889.

**THE FATALITY OF MEASLES.**—Sevestre, at his clinic on diseases of children, speaks against the prevalent idea that measles is not a dangerous disease. There died in Paris during 1887, 1769 cases of diphtheria and 1674 of measles, while scarlatina and whooping-cough claimed respectively only 232 and 429 victims. He has found measles especially dangerous between the second and third years of life; the infecting agent is especially active during the period preceding the eruption.—*Semaine Med.*, 42, 1889.

[Hufeland more than half a century ago taught that many deaths from pulmonary phthisis late in life result indirectly from measles.—S. L.]

**ACTINOMYCOSIS.**—Dr. Julius Fessler, of Munich, gives the following characteristics of actinomycosis:

1. A stubborn, torpid course of the swelling, without fever or marked pain.
2. A marked stretching and hardness of the affected region.
3. When the process is situated on or in a bone, the soft parts become tightly adherent to it by means of firm, cord-like tissue.
4. After the lapse of weeks or months, superficial, circumscribed breaking down occurs, with discharge of the broken-down tissues externally, without violent symptoms.
5. The discharge consists of a scanty, blood-tinged serum, in which it is possible to demonstrate the presence of gland *débris*.
6. Healing of the point of exit occurs rapidly, the whole swelling decreases slightly in size, but increases again in a few weeks.
7. Extensive breaking down only occurs late.—*Monatsh. für prakt. Dermatol.*, Bd. 9, No. 8, 1889.

**LUPUS TREATED WITH ICE.**—Klaus Hansen (*Med. Revue*) reports the case of a woman treated for a long time for lupus of the lower lip by means of caustic applications, scraping with the sharp spoon, etc. A cure was not affected; on the contrary, new lupus nodules developed in the surrounding tissue. At the same time so high a degree of sensibility took place in the affected parts that the slightest irritation, even the application of iodoform, caused such severe and long-continued pain that even cocaine was powerless to relieve it.

The author now applied ice, as recommended by Gerhardt, with the result that within three days the pain was entirely relieved, and after the lapse of several weeks a complete cure resulted, which suffered no relapse after three months.—*Journal of Cutan. and Genito-ur. Dis.*, November, 1889.

**SYPHILIS OF THE HEART.**—In a recent article, Mauriac gives a *résumé* of the facts known about syphilis attacking the heart. He considers such complications as among the rarer manifestations of visceral syphilis. It develops, on an average, about ten years after infection, being a tertiary form; the heart muscle is oftener affected. The endocardium is oftener the site of the lesions than the pericardium. It is peculiar that the valves generally remain normal in the majority of cases. The lesion is usually a localized interstitial myocarditis, which does not manifest any marked differences from other inflammations, and is to be differentiated from the deposition of typical solitary or miliary gummata, although both forms of disease may co-exist. The gummata may break down and rupture into the heart cavity, as Oppolzer has observed. Syphilitic disease of the heart is frequently accompanied by a periarteritis of the cardiac vessels.

The clinical picture presented by the disease varies very much, and its diagnosis must almost always rest upon the previous history and the development of other syphilitic manifestations. In a few cases the results of treatment will prove the correctness of the diagnosis. The course of cardiac syphilis is usually insidious; its duration is uncertain, and death frequently occurs suddenly.

According to Mauriac, the prognosis is exceedingly unfavorable, as almost all cases terminate fatally. He, however, suggests that there is a possibility of mild cases occurring which escape diagnosis, while those in which death occurs the diagnosis is made certain by the autopsy.

In the cases collected by Mauriac, death occurred suddenly in 50 per cent. Sudden dyspnoea, coma, asystole, albuminuria, gangrene, and diseases of the brain, are the consequences of cardiac syphilis.—*Archiv. für Dermatol. und Syphilis*, Heft. 4, 1889.

**THE TREATMENT OF SCARLET FEVER BY CHLORAL HYDRATE.**—J. C. Wilson, *Medical News*, December 14, 1889, recommends, on account of a personal experience extending over seven years, the use of chloral hydrate in the treatment of scarlet fever; it is administered as follows: Chloralis, gr. xxx; syrup lactucarii (Aubergier) and water, each ʒjss.—M. A teaspoonful in iced water given every two, three or four hours, with the administration of nonnishment immediately after the medicine; the object being to keep the patient in a condition of light repose. The doctor has found the treatment of scarlet fever by chloral hydrate without the use of other drugs has yielded satisfactory results. 2. The chief rôle of chloral in the treatment of scarlet fever is that of a sedative to the cerebral centres; it appearing to antagonize certain exciting toxic principles formed within the organism during the course of the disease. 3 Chloral is also useful on account of its antiseptic properties (a) upon the throat; (b) upon the kidneys; (c) to a slight extent upon the fluids of the organism at large. 4. The elimination of chloral by the kidneys and its diuretic effect render it especially useful in the treatment of scarlet fever.

**DIURETIC ACTION OF CHIMAPHILA UMBELLATA.**—Abet has treated eleven cases of cardiac disease in which there were more or less œdema and considerable dyspnoea, with a watery infusion of an alcoholic extract of chimaphila umbellata, and in ten of the same, with decidedly beneficial results. Diuresis began as early as the second day of the administration of the drug. The daily amount of urine discharged sometimes reached five litres. After the disappearance of the œdema, the quantity of urine excreted sank to the normal. The drug exerted no effect on the heart.—*Bull. Gen. de Therap.*, 64, 1889.

[The above verifies an observation made by Dr. S. A. Jones, in the *American Observer*, xii., 300. A patient with ascites took a strong infusion of the plant; on the following night he voided more urine than he had in all the previous seventy-two hours put together. The color of the urine changed from that of brick dust to the exact hue of the infusion drank. A young man who had taken a pint of the infusion had his sleep disturbed by constant calls to make water.—S. L.]

## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

**A SIMPLE REMEDY FOR COCCYGODYNIA.**—Parvin claims that in many cases of coccygodynia the hypodermic injection of warm water will be followed by great relief.—*College and Clinical Record*, November, 1889.

**A CURE FOR STERILITY.**—In cases of sterility dependent upon excessive acidity of the vaginal secretions, Parvin recommends the use of the following injection just before copulation:

R. Sodii bicarb.,	.	.	.	.	.	.	.	.	gr. xij.
Glycerinæ,	.	.	.	.	.	.	.	.	ʒi.
Aque destillat.,	.	.	.	.	.	.	.	.	ʒiʒ iv.—M.

—*College and Clinical Record*, November, 1889.



**PREMATURE LABOR INDUCED BY IODOFORM TAMPONS.**—Chenevierre introduced the following method in three cases of induced labor: The vagina being thoroughly disinfected, the cervix was brought into the lumen of the speculum and the anterior lip held with a pair of forceps. About twenty small iodoformed tampons were then introduced into the cervix as high up as possible. After this, a large tampon saturated with a carbolized solution was introduced into the vagina. In one case, one tamponing was sufficient in the course of fourteen hours to bring on labor. In both the others it was necessary to renew the tampons, or rather others were pushed in after them, whereupon the labor came on. From one patient a cluster of the tampons were expelled the next day after the confinement. This might have been prevented if the operator had used, instead of a number of tampons, but one long strip of iodoform gauze.—*Centrablatt für Gynäkologie*, October 26, 1889.

**THE TREATMENT OF ENDOMETRITIS.**—Dr. Paul F. Munde employs the following treatment in endometritis with hyperplasia of the mucous membrane: After dilating the cervix when it is necessary, the cavity of the uterus is thoroughly mopped with a 50 per cent. solution of zinc chloride, the applicator being introduced several times, that none of the endometrium escape canterization. The uterine cavity is then plugged with cotton smeared with vaseline, and an iodoform tampon is placed under the cervix. The patient is put to bed with an ice-bag over the hypogastrium. After two days she is allowed to get up, the tampons are removed and douches of 2 per cent. carbolized water given twice daily. After the sloughs have separated from the endometrium, in a week or ten days, another application of chloride of zinc is made to the cavity. The carbolized douches are continued, and when the discharge lessens somewhat in amount, gelatine-coated pencils, containing five grains each of iodoform and alum, are inserted into the uterus.—*Annals of Gynecology*, November, 1889.

**INFANTILE MENSTRUATION.**—Dr. J. A. Dickey reports a case of a child, now two years of age, found in the mountains of Virginia, who commenced menstruating at the second month, and has continued regularly ever since. The mammary glands are largely developed and the hair, half an inch long, covers the mons veneris. She possesses the shame and bashfulness of a young lady, and will not permit the hands in proximity to the mammary glands.—*American Medical Journal*, November, 1889.

**CONTRIBUTION TO THE STUDY OF THE PATHOGENESIS OF THE ALBUMINURIA AND ECLAMPSIA OF PREGNANCY.**—Dr. Emile Blanc says: "At the beginning of the year 1889 we found in the urine of eclamptic women a microbe with intense and well-defined pathognetic effects. During the course of the summer we went on with these researches, and extended them to the albuminuria of pregnancy, which seemed in some cases to have a microbe origin. In these women with albuminuria as well as in the eclamptics, we have examined and cultivated the blood and urine. With the fertile cultures of these liquids we have made a series of inoculations in fourteen rabbits, four of which were in a condition of gestation." In the albuminuria of pregnancy they found different species of micro-organisms, but he refers to only two. 1. Several varieties of cocci, and, 2, a slender bacillus, regular, short, and having a length of one to three times its breadth. With cultures from these micro-organisms, they inoculated by intra-venous injections only non-pregnant rabbits. The cocci had no very marked pathological effect, but cultures from the bacilli sometimes caused speedy death, and sometimes grave symptoms of defective nutrition, lowering of temperature and paraplegia, accompanied by albuminuria. In two or three cases there was swelling and gangrene at the points of inoculation with general symptoms. In urine from eclamptic women they were able to demonstrate the presence of an elongated coccus or rather short bacillus. In one case a non-pregnant rabbit injected with cultures of these, developed anuria, albuminuria and prostration, resulting in death. Some pregnant rabbits placed in a box which had held several inoculated animals, and in which two had died, developed albuminuria, and dropped their young. Still others which were inoculated exhibited convulsive phenomena and intense albuminuria, followed by death.—*Canadian Practitioner*, December 2, 1889.

**THE ABORTIVE TREATMENT OF ACUTE PELVIC INFLAMMATIONS.**—Virgil O. Hardon, M.D., believing that pelvic inflammations are almost universally depen-

dent upon diseased conditions of the uterine appendages—ovaries and tubes—and that the proper treatment is removal of these organs, when diseased, by laparotomy, recognizes the impracticability of always adopting this line of treatment. The circumstances of the patient may render it impossible. Secondly, the gravity of the disease, to their minds, does not justify such an operation. Again, the height of an acute inflammatory attack is not the period of election for the operation. For these cases he recommends the following treatment: In acute cellulitis where there is the boggy, oedematous feeling of the roof of the vagina, either at the sides of or behind the uterus, or in any number of these localities, he withdraws from the cellular tissue the effusion, by means of the aspirator. The patient is placed in the dorsal position, with the legs flexed, and with the vagina, hands and instruments rendered aseptic, the finger is introduced into the vagina to locate the effusion and guide the aspirating needle. The ordinary exploring aspirator needle is then thrust into the cellular tissue to a distance of half an inch, and the piston withdrawn until the fluid, which is bloody serum, ceases to flow; this is repeated until the swelling and oedema have disappeared—usually, three punctures on the sides, and one or two behind the uterus. The pain is not severe, and an anæsthetic is seldom necessary. The relief is immediate. The second form of inflammation, pelvic peritonitis, he treats by active catharsis, as soon as the disease is recognized, beginning with teaspoonful doses of Epsom salts, every hour, dissolved in as hot water as can be swallowed, until watery stools are induced. From five to eight doses are usually necessary. If the patient has previously taken opiates to relieve pain, a larger number of doses is required. As soon as watery stools are induced, the pain is relieved, and the pulse and temperature begin to decline.—*Atlanta Medical and Surgical Journal*, December, 1889.

**IODOFORM GAUZE IN POST-PARTUM HÆMORRHAGE.**—Dr. O. Piering, assistant in Prof. Schauta's obstetric clinic in Prague, has published his experience in the employment of Dührssen's plan of plugging the uterus with iodoform gauze for post-partum hæmorrhage due to an atonic condition of the organ.

Dührssen recommends that, when post-partum hæmorrhage comes on, the bladder should be emptied, and forcible friction, intra-uterine irrigation with hot or cold water, and hypodermatics of ergotin employed; that if the hæmorrhage still continues, the cavity of the uterus should be filled with iodoform gauze, the irritation produced by this setting up active and permanent contraction. The method has, according to Dührssen, the advantages of great certainty, complete harmlessness and facility in its performance.

Olshausen, Veit, and Tehling, however, say that the contraction set up is not always permanent, and that the method is not so free from danger as Dührssen believes.

In consequence of these conflicting views, Dr. Piering resolved to give the method a trial, and he has recently detailed several cases in which it was employed with complete success. In no case was harm done by it. He advises that resort to the plug should not be too long delayed, and prophesies an important future for iodoform gauze in post-partum hæmorrhage.—*Lancet*, November 9, 1889.

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## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

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**EXTRACTION OF IRON FRAGMENTS FROM THE VITREOUS WITH THE MAGNET.**—Dr. F. C. Hotz, of Chicago, states that the presence of iron in the vitreous alone is not a sufficient indication for this operation; besides being convinced the foreign body is in the vitreous, we must also have good reason to believe that after the removal of the iron the eye will recover, if not any vision, at least such a good condition that its preservation is an object to the patient, and that it will not become a source of danger to the other eye. Consequently, he does not consider the operation applicable to cases where the eye has been so extensively wounded that, foreign body or no foreign body, the lesion itself will necessarily cause complete atrophy of the eyeball; nor is it applicable to eyes in which the irido-choroiditis, incited by

the foreign body, is so far advanced that the unavoidable result will be an irritable and dangerous stump, even if the magnet operation be successful.

The degree and extent of the traumatic inflammation has to decide the question whether or not the magnet can be employed with advantage, and to the benefit of the patient. The best result, of course, is promised by those eyes which show little or no inflammation, either because they are seen very soon after the accident, or because the eye has shown an unusual degree of tolerance to the foreign body. The last of the three cases reported in the article, although in it the magnet failed to extract, is instructive, as showing a cause for failure in this operation. A horse-shoer, one week before presenting himself, received a fine piece of steel in his right eye—dimness of sight, pain and inflammation, appeared first, two days later. Examination showed: pericorneal injection; a minute scar at the temporal sclero-corneal junction; pupil dilated by atropine; lens clear; vitreous hazy, but still permitting a bright, shining body to be located in its temporal section a little above the horizontal line. Tn., V-fingers at one foot. Cocaine ineffective; under chloroform a meridional incision was made, two and a half millimetres long, between the rectus externus and inferior; a Gruening's magnet was introduced in the direction where the foreign body had been located by the ophthalmoscope. This whole region was most carefully explored, but without result, although twelve different trials were made. The ball being then enucleated, and opened, the steel was found as located by the ophthalmoscope, three millimetres from the retina. The magnet was now reintroduced, as in the operation, when as it approached within one millimetre of the steel, the latter was seen to jump towards and cling to the point of the magnet, and when the magnet was slowly withdrawn, the scale followed it till it had moved about two to three millimetres from its position, when it suddenly sprang back, as if jerked by an elastic string. On finally removing the steel with forceps, the fibrinous bands surrounding it were found so firm as to drag a portion of the vitreous with it, this clearly explaining the inability of the magnet to draw it from its position.—*Am. Journal Ophthal.*, September, 1889.

**EPILEPSY, CHOREA AND THE EYE-MUSCLES.**—The commission appointed by the New York Neurological Society to investigate the relation of the insufficiency of the ocular muscles to chorea and epilepsy, made its report in November last, and after an animated discussion, which was continued at the December meeting, the report was adopted.

In a paper by Dr. George T. Stevens, published a few years ago, it was asserted that about 50 per cent. of epileptics were relieved of their attacks by the treatment of insufficiencies of the ocular muscles. Dr. Stevens has since then obtained some confident and aggressive followers, and, consequently, considerable attention has been attracted to his method. The committee appointed to test the validity of Dr. Stevens's statements worked in co-operation with the doctor, and having found a suitable case of idiopathic epilepsy or chronic chorea, had the patient examined separately by two of its neurological members and a full history taken. The patient was then sent to Dr. Stevens and examined by that gentleman. If acceptable, further eye examinations were made again by one of the ophthalmologists of the commission. Each patient, therefore, went through four separate examinations before treatment was begun. Records were then kept of operations performed, and of the progress of the case. Twenty-eight patients were thus examined and put under treatment, but, for various reasons, four were withdrawn. Fourteen, however, were treated continuously for over four months, and, in some instances, over two years. Nine of these cases were of epilepsy; five of chronic chorea. Three of the cases of epilepsy and three of chorea were improved. None were entirely and completely cured, although two of the cases of chorea seem to have become practically well. None of the cases of epilepsy were cured or even strikingly improved, though as to this latter point there seems to be some difference of opinion. The commission, in their conclusions, state that they cannot recommend a treatment of ocular muscles in cases of epilepsy and chorea as the sole therapeutic measure, or as a curative measure. This conclusion does not deny to oculo-muscular treatment all value, but it is evident, from a perusal of the discussion, that the members do not attach very much importance to it. Although the extravagance of Dr. Stevens's claim is thus shown, it was certainly a most courageous act on his part to put his method to so exacting a test, and argues an honest conviction on his part in the truth of his own views. The exact importance of functional eye disturbances in the production of morbid symptoms and the pathogeny of disease, time will determine definitely.—*N. Y. Medical Record*, December 21, 1889.

**RELATIVE IMPORTANCE OF REFRACTIVE AND MUSCULAR ERRORS IN THE CAUSATION OF HEADACHE.**—A paper by Dr. F. W. Marlow, upon this subject, is based upon the records of two hundred and fifteen cases occurring in private practice. Headache is perhaps the most common nervous symptom attributed to ocular mal-adjustment, but is far from being the only one, and in many of the cases in which headaches are noted as being absent, other nervous symptoms are present, dizziness coming next in frequency to headaches; other symptoms being nausea upon the use of the eyes, twitching of the eyelids, slight general choreic movements, rapid exhaustion upon exertion of any kind, and insomnia. As a result of a review of his cases, the author comes to the following conclusions:

1. That headaches are frequently the result of refractive errors and muscular insufficiencies.
2. That refractive error is a more common factor in the production of headache than muscular error.
3. That muscular error is more certain to produce headache than refractive error.
4. That astigmatism is the most common and powerful refractive factor in the production of headaches, and, of the different forms of astigmatism, compound hyperopic astigmatism is the most important in this regard.
5. That insufficiency of the superior and inferior recti, either simple or complicated with insufficiency of the lateral muscles, is a common form of muscular error.
6. That error in the vertical movements is more certain to produce headache than any other form of muscular or refractive error.
7. That a combination of vertical muscular error with astigmatism is the most powerful cause of ocular headaches.—*Ophthalmic Review*, December, 1889.

**ON SOME RELATIONS BETWEEN THE DISEASES OF THE NOSE AND THE EYE.**—Statistics prove that in about one-half the cases of *epiphora*, the symptoms are caused by some stricture or affection in the canal *iculi* or lachrymal sac. In about one-third of the cases, there is no stricture, the lachrymal sac being most affected. The first class of cases is amenable to the usual methods of treatment, the probe, etc., but in the latter, the *epiphora* returns again and again, simply because the seat of the disease is in the mucous membrane of the nose, and until we cure this we cannot prevent the inflammation from spreading to the nasal duct and obstructing the free passage of the tears. Nearly all persons who are subject to chronic hypertrophic rhinitis, suffer from *epiphora*. Dr. Gruhn (*Centralblatt für Augenheilkunde*, 88) found that out of thirty-eight cases of *blenorrhœa* of the sac or *mucocœle*, the nose was affected in thirty-six. Dr. Kruch (*Annali di Ophthal*, 87), reports that out of thirty-five cases the nose was affected in thirty. In *phlyctenular conjunctivitis* and *keratitis* the attack will not often yield, or will repeat itself indefinitely, until the commonly accompanying rhinitis is cured. Nieden (*Archiv Augenheilkunde*) thinks that *ozœna* is partly due to a closure of the nasal duct, and that thus the tears cannot enter and moisten the nasal mucous membrane. Ziem (*Allg. Med. Central. Zeitung*, 86) draws attention to the fact that in most cases of *granular lids*, there is also rhinitis. The writer, as well as Gruning, Ziem, Bettman and Maxwell, report cases in which *muscular asthenopia* and *recurrent enlargement of the conjunctival vessels* were found dependent upon a hypertrophic rhinitis; as, when these conditions had stubbornly resisted all other forms of treatment, they promptly disappeared upon the cure of the nasal disorder. Ziem Woakes and others, have proved that some cases of hypertrophic rhinitis, and also *empyema* of the maxillary sinus, can give rise to *scintillating scotomata*, *amblyopia*, *contracted field of vision* and *glaucoma*; and dimness of vision and contraction of the visual field, have also been observed after the application of the *galvano-canthery* to the mucous membrane of the nose.—Dr. Adolph Bronner, in *Journal of Laryngology and Rhinology*, Amer. Edition, December, 1889.

**IMPORTANCE OF EXAMINING THE EARS IN TROUBLESOME COUGHS.**—Dr. Alfred C. Palmer, in a paper before the Medical Society of North Carolina, calls attention to the frequency of aural inflammation and irritation, as an unrecognized cause of troublesome coughs. Since, anatomically, we are able to trace a direct connection between the tympanum and larynx first through Jacobson's nerve to the petrous ganglion of the glossopharyngeal, then through this and its connecting fibres, where they exist, into the pneumogastric and its branch, the superior laryngeal, to the whole of the mucous membrane of the superior part of the larynx, it is reasonable to suppose that should irritating influences exist in the tympanum, there must nec-

essarily be some manifestation at the other end of the connection. This influence might not be evident, were it not true that the superior laryngeal terminates in so sensitive a membrane, made so by its own presence; hence many of the troublesome hacking coughs which we are so prone to attribute to reflex stomach troubles (dyspeptic coughs), sub-acute laryngitis, bad colds and the like, are directly due to a disturbance of one kind or another in the ears, and that where these cases come under our observation, we will often reach a satisfactory diagnosis and treatment by making a thorough examination of these organs. The doctor reports several cases in illustration.—*North Carolina Medical Journal*, November, 1889.

**NEW ANTISEPTIC ARTIFICIAL MEMBRANA TYMPANI.**—Dr. John Ward Cousins, in the *Medical Press* (Eng.), November 13, 1889, tabulates the essential qualities of a good artificial drum-head, as follows:

1. It must decidedly improve the hearing power, both for distance and conversation.
2. It must be so constructed that it can be easily placed in the right position and removed; and be also adapted for self-application.
3. It must be light and delicate in structure, and cause no irritation by its presence.
4. It should be a protector to the tympanic cavity.
5. It should be capable of fitting the varying capacity of the external meatus.
6. It should be a convenient vehicle for the application of local remedies.
7. It should be obtainable at trifling cost.

The apparatus described by Dr. Cousins is made of compressed cotton fibre, swollen by prolonged immersion and saturated in an antiseptic oil and ether; the soft material is then firmly compressed and shaped in a machine devised for the purpose, and dried by artificial heat. In shape it is exactly like a hat, with a very high and tapering crown, and a broad and flat brim, having a short ribbon attached to the edge. It is firm enough to retain its shape in the ear, and yet the material is so soft and flexible as to cause no sensation by its presence. When in position, the crown rests near the tympanic membrane, the brim upon the meatal walls, and the little ribbon or handle behind the tragus. It is introduced and removed without difficulty, by means of a combined forceps and probe. The apparatus has been tested by Dr. Cousins in more than one hundred and fifty cases of middle ear disease, with decided benefit in all but three.

**DIPHTHERITIC PARALYSIS OF ACCOMMODATION.**—In a clinical study of post-diphtheritic paralysis of the accommodation, Sym states the following characteristics of this affection: 1. Its remarkable frequency following attacks of diphtheria. 2. The comparative rarity after other acute diseases. 3. The curious selection of the seat of the paralysis. 4. The fact that while one part is paralyzed another is at the same time in a state of healthy activity. 5. The paralysis does not come on immediately after the diphtheria. 6. It occurs after comparatively mild cases. 7. Pathological changes have been observed in some fatal cases, in the nerves, centres and muscles. 8. The symmetry of the paralysis. After due consideration of all these points, Sym concludes that the paralysis is produced by a toxic effect of diphtheria, or of the cause of diphtheria. He quotes Jacobi, who says that where the temperature in the primary disease has been high and the original reaction severe there is less likelihood of paralysis, owing to the more thorough removal of the poison from the system. A series of cases observed by Boissarie seems even to suggest that one may even have diphtheritic paralysis without diphtheria, for during an epidemic of that disease he saw several examples of paralysis of accommodation of throat, of limbs, etc., in the persons of those who had not been affected with sore throat.—*Edinburgh Medical Journal*, November, 1889.

## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL VISCHER, M.D.

**SURGICAL TREATMENT OF TYPHLITIS.**—Mr. Frederick Treves, at the last annual meeting of the British Medical Association (*British Medical Journal*, November 9, 1889), presented an excellent résumé of the pathology and treat-

ment of the peritoneal inflammations in the cæcal region which have excited so much interest of late. He compares these inflammations to pelvic peritonitis, those following hepatic abscess, or tubercular ulcer of the intestine, and deprecates the numerous and useless classifications, peri- and para-typhlitis, appendicitis, etc. The pathology of this affection is summed up as follows:

1. Primary inflammation of the cæcum, aside from catarrh and ulceration of the mucosa, does not exist.

2. The cæcum and appendix are covered by peritoneum; therefore, their perforation cannot lead primarily to suppuration of the connective tissue of the iliac fossa.

3. Cæcal catarrh may occur, but is associated with a colitis and produces the symptoms of this disorder and not those of typhlitis, even when acute.

4. Cæcal ulceration may be due to impacted feces, tubercle, typhoid, dysentery, or foreign bodies. As long as these ulcers are confined to the mucous membrane they do not produce the symptoms of typhlitis. In stercoral ulcers, perforation or involvements of the outer coats appears late and is preceded by symptoms of fecal obstruction.

5. Primary perforation of the cæcum is rare, but it may occur secondarily by an abscess from the appendix opening into the caput coli.

6. Abscesses, the result of perforations in the cæcum or appendix, are primarily intraperitoneal, that is, encysted suppurative peritonitis.

7. Mild forms of typhlitis are caused by stercoral ulcers invading the outer walls of the cæcum; severe and suppurative forms by foreign bodies or twists in the appendix; on the other hand, mild forms may be the result of disease in the appendix, and such disease, though severe, may not result in suppuration.

8. The cause of mischief in the appendix may be a fecal concretion (50 per cent.), foreign bodies (12½ per cent.); it may be twisted on itself and strangulated; the lumen may be obliterated and distension result, or ulceration may be present. The abscess may point in the abdominal wall (28 out of 67 cases); it may open into the cæcum (15 out of 67); the abdominal cavity (8 cases); the rectum, the bladder, the thorax (2 each).

Typhlitis may be divided into three classes:

I. *Mild*.—The more common, usually ending in resolution and responding to medical treatment. It is caused by fecal impaction or irritating matter. The stercoral ulcers extend beyond the mucosa and cause some peritonitis. The trouble may be in the appendix and result in obliteration and shrinkage of the same, with numerous adhesions. Symptoms: Constipation with scybala, or diarrhœa produced by the latter (colitis); sudden pain, but not as severe as in the suppurative form, nor does it radiate to the testis or thigh; less fever (usually no chill), less vomiting, less tenderness, but a larger, earlier, doughy tumor, which cannot, however, be made out through the rectum; no cystic symptoms. The attack usually passes off in from three to seven days. The severe forms may begin like this, but the absence of the signs of suppuration is of importance in distinguishing between them. The patients are usually young, adult males: 36 per cent. under twenty years; 21 per cent. over forty. In perforating appendicitis 50 per cent. are under twenty and 9 per cent. over forty.

II. *Severe*.—Almost always due to diseased appendix and results in suppuration. The symptoms are more exaggerated and the progress more rapid; there is a chill; no previous constipation or indigestion; perhaps cold or injury (or strain.—Ed.); severe pain, which is apt to radiate to the testis or thigh, and is increased on moving the latter; dysuria; marked tenderness; high fever; vomiting; the tumor appears late, is fixed, can be felt per rectum; fluctuation. The intensity of the symptoms may vary from those of the mild form to a fulminating attack, in which the patient is moribund in two days or less.

III. *Relapsing*.—Due to disease of the appendix falling short of suppuration and not to stercoral cæcal ulcers. Attacks recur irrespectively of constipation and with increasing vigor, leaving the patient in impaired health. These are caused by retained mucus from a twist following adhesions or stricture after the healing of an ulcer; occasionally they may be produced by a foreign body causing complete perforation in successive attacks (or to a catarrhal ulcer.—Ed.).

*Treatment*.—(1.) In the first form, medical treatment will suffice; rest, the cautious use of opium, little fluid food, counter-irritation, enemata and subsequent careful diet, etc. To the fact that these cases recover is due the opposition of many medical men to operative interference in typhlitis.

(2.) In the form in which suppuration is to be looked for, surgical intervention

is indicated, the previously-mentioned medical treatment being, of course, added. Opium should be given with great care as it may mask important symptoms.

Three points are to be thought of in considering the operative treatment, *i.e.* :

(a.) *When to Cut.*—This will never be called for, barring exceptional cases, before the fifth day; usually after the first week. The indiscriminate early incision recommended by some American surgeons, notably Bull, is to be deprecated. Occasionally an abscess opens quickly into the peritoneal cavity, but then the symptoms of perforative peritonitis call for immediate laparotomy. On the other hand, a large proportion tend to open externally, and the longer the operation is delayed, the firmer the adhesions are apt to be; besides, early incisions would often open a pus cavity before adhesions had taken place with the parietes and cause general peritoneal infection. It has been shown that 68 per cent. die during the first eight days, and two-thirds of these from the fourth day on; the signs of this *deep-seated* suppuration should be, on an average, distinct, and the pus more or less firmly encysted by the fifth day, which, with the self-evident reservations, is the average time for safe incision.

(b.) The *exploring needle*, to detect the presence of pus and as a preliminary to incision, is to be condemned. A cautious exploratory incision is preferable to these thrusts in the dark, which may, after all, not strike the abscess. The needle may precipitate a perforative ulceration, give exit to pent up putrid secretions, or wound important structures.

(c.) The *incision* should be over the seat of suppuration, and should permit a direct evacuation of the pus. This is best accomplished, in most instances, by an oblique incision from above downward, ending a little above and to the outer side of the middle of Poupart's ligament, *i.e.*, just external to the deep epigastric artery. This should take the same general direction as that used to ligate the iliac artery. An incision in the linea semilunaris will not usually allow direct evacuation of the pus, while that in the linea alba will be external to the localized pus cavity, and on opening the latter, the general peritonæum *must* be impacted. Of course, the incision will have to be modified by variations in the position of the cæcum. The opening should be free, but the abscess cavity should be but little handled, for fear of breaking up adhesions. It should never be scraped. Fæcal concretions or foreign bodies should be sought for, and if the appendix is readily found, and non-adherent, it may be tied off, provided it is not *entirely* gangrenous, *i.e.*, presenting no stump to ligate. The cavity should be irrigated and drained. Perforation of the cæcum is better left alone; plastic closure is, of course, out of the question, and very difficult later on. Fortunately, these fæcal fistulæ close spontaneously with proper care.

In contrast with this article is a plea for "early operative interference in cases of disease of the vermiform appendix," by McBurney (*N. Y. Medical Journal*, December 21, 1889). He also proposes to discard the various distinctive names applied to inflammations about the cæcum, and to consider them all, for practical purposes, as originating in the appendix to which they are secondary. At least ninety-nine out of every hundred cases of acute inflammation in this region are due to diseased appendix in its different stages. An early diagnosis of such disease is all important. Pain is an unreliable symptom, as it is often not marked or absent in the iliac fossa, being most commonly epigastric or general. Extreme sensitiveness at the base of the appendix elicited by pressure with one finger tip is almost pathognomonic. This point will be, as a rule, two inches inside of the anterior superior iliac spine on a line drawn from it to the umbilicus. Chill and vomiting are of but little diagnostic value; so, too, with tympanitic distension, which depends on the condition of the bowels and the paresis of the colon produced by the peritoneal inflammation. Fever varies greatly, but its presence serves to exclude non-inflammatory troubles. Rigidity of the abdominal walls on the affected side is very constant. A tumor is usually present, and can always be found under ether. It may consist of a mass of adherent intestinal coils, a distended appendix wrapped in the omentum, or a circumscribed collection of pus. Rectal examination is negative at the beginning. The use of the exploring needle is deprecated. These symptoms will render a diagnosis possible, but will not decide the stage or prognosis unless a sudden aggravation indicate perforation or bursting of the abscess. The abscess often forms insidiously, and a sneaking septic peritonitis may develop unperceived. In view of these facts and the terrible resulting mortality in cases published, and far more not published, recognized and often unrecognized, the author recommends immediate exploratory incision as soon as a diagnosis of ap-

pendicitis is made. In support of this advice he cites eleven cases of his own treated on this principle with one death. These were all operated early, that is, as soon as possible after they were seen. In the fatal case there was a delay of twelve hours. In every one the diagnosis of acute inflammation of the appendix was made and subsequently confirmed. The reported cases do not include those in which a comparatively "safe" large abscess was seen to be developing, or where general septic peritonitis had supervened.

As regards the operation, a free incision is desirable. It is best made along the right border of the rectus, with its centre on or below a line drawn from the anterior superior iliac spine to the umbilicus. The adhesions are to be broken down or tied off, and the appendix cut away between two ligatures. The stump is disinfected or cauterized and replaced. The wound is partly closed, a drain inserted and iodoform gauze packed down to the stump. Or the drain may be passed in through a counter-opening in the loin. If the appendix cannot be removed, the cavity is to be disinfected, packed and drained. Extreme obesity is a contra-indication to operation, while excessive tympanitic distension is such until removed.

**THE OPERATIVE TREATMENT OF RELAPSING TYPHLITIS**—Treves was one of the first to do a premeditated excision of the appendix for relapsing typhlitis between attacks. He reported a successful case to the Medico-Chirurgical Society of London, February 14, 1888. The man, thirty-four years of age, had had two attacks of typhlitis, and during a period of freedom from all symptoms, laparotomy was performed and a diseased appendix removed. Recovery and cure resulted. Another case is reported by the same surgeon in the *London Lancet*, February 9, 1889. The patient was a man of twenty-nine years, who had always led a regular life, and had been free from intestinal trouble. The first attack was sudden and apparently without cause, and the convalescence very slow; the second, two months later, began in a like manner, but was more severe and the convalescence longer; a third attack followed in three months with greater intensity, and the patient was left with the prospect of being at best a confirmed invalid. The operation was performed when all inflammatory symptoms and tenderness had disappeared and the digestive functions were at their best. There was dulness and a sense of resistance in the cæcal region, and the appendix could be made out on deep palpation. The cæcum and appendix were buried in adhesions; the latter was distended with mucus retained by an acute flexion; there was ulceration of its wall, which threatened speedily to cause perforation. Recovery was uncomplicated, and the patient completely and permanently cured. The writer thinks the following points are of importance in performing the operation:

1. The position of the appendix should be ascertained if possible.
2. The operation should be done after all the symptoms have subsided.
3. The incision should open the abdomen beyond the seat of disease to avoid adhesions to the parietes.
4. Adhesions should be cut, not torn, for fear of injuring the bowel. Also other adhesions which might cause subsequent mischief should be divided.
5. The appendix should be tied off, the end closed by a double row of sutures and attached to a neighboring peritoneal surface.

Senn reports (*Journ. Amer. Med. Assoc.*, November 2, 1889) two similar cases, one from his own practice and one from that of Hoegh. His own case was that of a young man, aged twenty-two years, who had had five attacks of typhlitis. During the intervals he had never regained his former health, but was free from pain and constipation. There was no tumor, but the appendix could be felt behind the cæcum. He was operated on during the sixth attack, the bowels having been previously cleared by a purge and an enema. The incision was over the cæcum and parallel to the ascending colon; there were no adhesions, but the mesentery of the appendix was shortened and vascular; its peritoneal covering was normal. The mesentery was tied off in sections, the appendix ligated close to the cæcum and amputated. The stump was buried by stitching the peritoneum over it. The patient was at work in three weeks, and has remained well since. The appendix contained a catarrhal ulcer which had already destroyed part of the muscular coat. The other case was also a man, thirty-seven years old, who had been subject to attacks of typhlitis for six or seven years, five attacks having occurred during the preceding fifteen months. These were increasing in severity, and the general health had become impaired to a marked degree. There was no tumor, but circumscribed tenderness in the cæcal region. The linea semilunaris was incised, and an inflamed and



slightly adherent appendix removed in the same manner as in the former case. It contained pus and two ulcers.

After reviewing the indications for, and the technique of, such operations, the writer gives, among others, the following conclusions:

1. All cases of catarrhal and ulcerative appendicitis should be treated by excision of the appendix as soon as the lesion is recognized.

2. In simple, uncomplicated appendicitis excision is easy and safe.

3. If done before perforation has taken place, excision is curative as well as prophylactic.

4. The most constant and reliable symptoms of appendicitis are recurring pains and tenderness.

Baldy (*Medical News*, November 23, 1889) details three cases in which he removed the appendix.

(1st.) Laparotomy for pelvic inflammation; appendix adherent to right Fallopian tube; it was tied off and found to be "cheesy and friable."

(2d.) Laparotomy for ruptured left tubal pregnancy. On breaking up numerous adhesions in the right iliac fossa, a diseased appendix was found and excised.

(3d.) Median laparotomy for prolapsed and tender ovaries and recurring pain in the right iliac fossa; operation during an attack; appendix imbedded in adhesions, excised, and found to be cheesy and friable.

While these cases cannot, of course, be classed with those of Treves as premeditated excisions for relapsing typhlitis, they show that an examination of this region during a laparotomy may find conditions requiring interference that will be both prophylactic and curative. One Austrian operator we know of goes so far as to excise the appendix *any way*, when he comes across it during an operation, to prevent future possible troubles. We have felt the temptation to do the same on several occasions, but were restrained by the thought that everything in the make up of our bodies may have a purpose, although we do not as yet understand it. Disease of this portion of the intestinal tract, the cesspool organ, with but feebly developed muscular walls to expel its contents, certainly merits consideration, and an examination of this neighborhood should, undoubtedly, be part of the routine of an abdominal section.—ED.

More recently, McBurney, in the article quoted, refers to two cases in which he removed a diseased appendix after the subsidence of all symptoms. They were both young ladies, and had suffered from recurring attacks of typhlitis, the one having had twelve in one year and the other four. In one the appendix was found rigid, swollen, but non-adherent; the mucosa inflamed and the walls thickened. In the other there were firm adhesions, and the organ was dark-colored, swollen, soft, strictured, and contained some fecal grains. They were both cured.

**TREATMENT OF FRACTURES OF THE NECK OF THE FEMUR BY IMMEDIATE REDUCTION AND PERMANENT FIXATION.**—Senn, in an article on the above subject, shows the importance of a very careful and systematic examination in all injuries about the hip-joint. As the slightest roughness is at times the cause of incalculable harm, one is not justified in trying to demonstrate the objective symptoms. Very often an impacted fracture has been broken up by attempting to elicit crepitus or preternatural mobility. Inspection alone is very often all that is necessary to form a diagnosis. Where this does not suffice, measurement by the well-known lines will be all that is required. The diagnosis depends on the presence or absence of the three most important symptoms: 1. Position of the great trochanter. 2. Shortening. 3. Eversion. If a diagnosis of fracture has been made, the presence of impaction can easily be ascertained by carefully rotating the limb upon its axis, and by making slight traction. If the head of the femur is affected by these manipulations, impaction has occurred, and great care should be taken not to disengage the fragments.

The treatment recommended consists in the fulfilment of two principal indications: 1. Immediate reduction. 2. Permanent fixation. The first of these does not come into consideration where the fracture is impacted. The author has devised an apparatus which is adjusted by means of a plaster of Paris dressing, and which answers all purposes without necessitating the patient to remain in bed. It consists of a narrow strip of iron which is arched over the joint and fitted with several cross pieces, enabling it to be firmly fixed by means of the plaster dressing. Over the seat of fracture is a large pad which works with a screw in the arched portion, and is adjusted to hold the fragments in apposition. The direction of the

pressure should be made in a line with the axis of the femoral neck. The dressing is applied in the following manner: The patient is dressed in a pair of well-fitting knit drawers and thin stockings. The bony prominences are protected by pads of cotton, and, to strengthen the dressing about the joints, oak shavings are placed between the layers of plaster. The fractured limb is incased in the dressing as far as the middle of the thigh, when the patient is lifted out of bed. Great care should be taken not to disturb the fragments if impacted, and to guard against additional injuries in non-impacted fractures. The patient is now placed in the erect position, standing with his sound leg upon a stool about two feet in height; in this position he is supported by an assistant on each side until the dressing has been completed and the plaster has set. A third assistant should take care of the fractured limb, and see that the toe is on a line with the inner margin of the patella and the anterior superior spine of the ileum. A fenestrum must be made over the trochanter in order to apply the pressure by means of the "screw-pad." In order to secure perfect immobility at the seat of the fracture, it is necessary to include the entire pelvis and sound limb as far as the knee. The after-treatment is simple, provided the dressing has been carefully applied. The only thing requiring particular attention is the regulation of the lateral pressure. With this dressing the patient can move about in bed, and, the weather permitting, can be taken out of doors daily, without pain or risk of displacement of the fragments. At the expiration of eighty to one hundred days, the time required for bony union to take place, the dressing is removed, and the patient is cautioned not to step on the limb until the end of the fourth to sixth month, when union will be sufficiently firm to sustain the weight of the body. Passive motion should be begun as soon as the dressing is removed, and with this, massage to promote the nutrition of the limb. If muscular atrophy is marked, the use of the Faradic current will be of benefit.—*Journ. Amer. Med. Assoc.*

**ECHINOCOCCUS OF THE LUNG.**—Brunn reports the case of a patient who was taken ill with symptoms of croupous pneumonia, soon followed by profuse and offensive expectoration and the development of a cavity. During a severe paroxysm of coughing, pieces of membrane were brought up, which, according to Köster and Ribbert, had the appearance of echinococcus walls. After profuse expectoration, containing large quantities of these membranes, the patient recovered. The author thinks the echinococci were taken up by the lymphatics or the blood directly from the stomach.—*Deutsche Med. Wochenschrift*, No. 18, 1889.

**SALOL IN BURNS.**—Grätzer recommends salol in cases of burns, bruises and painful skin troubles of all kinds. He says it gives prompt and marked relief. The drug is simply dusted on the affected parts in a mixture of 2 to 3 parts of salol and 50 parts of starch.—*Medical and Surgical Reporter*, December 14, 1889.

**SAWDUST AS A WOUND DRESSING.**—The use of fine, soft sawdust, which has been freed from splinters and sharp bits of wood by careful sifting, has been suggested as a vehicle for antiseptics and for dressing wounds. It makes a clean and grateful dressing; also readily absorbs the discharges without packing or adhering. It is easily rendered aseptic by any of the methods used in preparing antiseptic cotton or wool. The *St. Louis Medical and Surgical Journal* suggests the use of yellow pine sawdust, which, being rich in turpentine, would of itself prove a valuable antiseptic.—*Medical and Surgical Reporter*, December 14, 1889.

**LANOLIN IN URETHRITIS.**—The well-known property of lanolin, that of adhering to mucous membranes, has been utilized by Dr. Stern in the treatment of urethritis. He uses a mixture of lanolin, 25 parts, and almond oil, 75 parts. This forms a mild and non-irritating injection, which may be used at the height of the disease. In the later stages astringents may be added. The injection should be retained for several minutes.—*International Journal of Surgery*, November, 1889, from *Therap. Monatshefte*.

**CHANCER OF THE FOREHEAD.**—Tschistiakow reports the case of a nursing child which was infected upon the forehead by a wet-nurse. This case is interesting owing to the rarity with which the primary lesion of syphilis appears upon the forehead, and also because the nurse had been examined by two physicians, an obstetrician and a specialist in syphilis, prior to being engaged. She had not been infected herself at the first examination, but had contracted the disease after beginning to nurse the child; which leads the author to call attention to the fact that a wet-nurse should not only be carefully examined before being engaged, but she should also undergo an examination from time to time afterwards.—*Archiv. für Dermatol. und Syphilis*, 1889, Heft. 4.

# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

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WITH THE COLLABORATION OF

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**A PROVING OF CHELIDONIUM.**—"Having met with this remarkable plant in June last, when in full blossom, a perusal in his *Materia Medica* of Teste's own proving of the drug, and of Buchman's elaborate provings in the *British Journal of Homœopathy*, induced me to make a tincture and to test Teste's statements on my own person, and an additional impulse being the rather fabulous (?) statements made by a Hereford firm of chemists as to certain unique powers their *celandine* was gifted with in causing corns to disappear. The actions I experienced in consequence of frequent—say the hourly—use of one-drop doses of the third decimal alcoholic plus 10 per cent. of glycerine tincture, continued during three days, were: On the whole surface of face an agreeable visible glow of heat; a transient cardiac pain; sharp pain under sternum; great aural flatulence every night when assuming the reclining position; on getting into bed a sharp spasm in chest, together with oppression of breathing and much cardiac anxiety (examination detected no organic disease); awful dreams; thighs itched; neuralgic pain in neck and left ear, back; kidney region weak and painful; sacrum painful when in bed; a cold feeling in stomach after food. Fourth day felt very queer; pharyngeal angina; pustule, like an incipient boil, on hip. Fifth day, much pain during previous night in sacrum and in rectum; blood passed at stool (never occurred before); spasm under sternum at night again.—"Agricola," *Monthly Homœopathic Review*, December.

**A CRITICAL ANALYSIS OF ARUM TRIPHYLLUM.**—There appeared in the December *New England Medical Gazette* a critical analysis of the provings of this drug, from which we abstract the following summary:

*Mind.*—Depressed and irritable.

*Head.*—Giddiness, heaviness and dulness of the head, with pressive pains, or darting, tearing pains.

*Eyes.*—Smarting of the eyes; tension and heaviness of the lids, with dimness of vision.

*Nose.*—Coryza, with a sore nose; upper lip corroded by the watery discharge; the nostrils obstructed, however, with sneezing.

*Face.*—Transient flushes of heat; lips chapped, sore, and feel first pricking, then sore, and finally scraped or scalded.

*Mouth.*—Mouth, including surface of tongue, inside of lips, fauces and palate, prickling, sore, and then scraped, scalded and sore, with burning in mouth, vessels even injected; lips feel chapped and rough inside.

*Throat.*—Sore, scalded and burning, with a feeling of constriction and pain in throat; mucus tough and increased, difficult deglutition; œsophagus sore and scalded.

*Stomach.*—Appetite reduced or gone; constriction in stomach.

*Abdomen.*—Indefinite, grumbling belly-ache.

*Stool and Anus.*—Diarrhœa; stool soft to diarrhœa; color, various.

*Urinary Organs.*—Increased urination.

*Sexual Organs.*—Cutting pains in testes or ovaries.

*Respiratory Apparatus.*—Irritation.

*Chest*.—Soreness of lungs.

*Lower Extremities*.—Pain in them.

*Sleep and Dreams*.—Sleepiness and yawning, especially in the evening.

*Fever*.—Transient flushes of heat.

**SUMMARY OF A CRITICAL ANALYSIS OF PODOPHYLLUM.**—"The administration of safe and applicable doses (tincture, extract, etc.) of this drug produces in many, in the majority of cases, the following symptoms: Headache (frontal), perhaps vertigo; (inflammation and turgescence of the eye); nausea (sometimes thirst); vomiting (of bile); tenderness and painfulness in the stomach and epigastrium; flatulence; frequent evacuations (diarrhœa) from the bowels of very thin, greenish fœces, accompanied by griping or colicky pains; (in the morning) weakness and faintness accompanying the gastric and abdominal symptoms; itching of the skin; slight vesicant effects; (pustules are formed if tincture is applied to the skin); chilliness, feverishness, perspiration (cold perspiration) accompanying the stool symptoms." The symptoms found in parentheses are not based on sufficient concordance and congruity in the records of the provings, but, due allowance being made for idiosyncrasy, they are regarded as possible symptoms.—Drs. Albert Pick and F. H. Pritchard, *New England Medical Gazette*, December.

**INDICATIONS FOR BISMUTH IN NEURALGIC PAIN.**—The most excruciating pains, relieved by continually walking about and by taking cold water in the mouth; worse by mastication and the touch of warm food; lancinating, burning pains, as though the face were torn by pincers; solitude unbearable.—S. L., *California Homœopath*, December.

**INDICATIONS FOR CACTUS GRANDIFLORA IN NEURALGIA.**—Clock-like regularity of the quotidian attack; pains pulsating, throbbing, constricting right side; worse from slightest motion.—S. L., *California Homœopath*, December.

**INDICATIONS FOR CHELIDONIUM IN NEURALGIA.**—After injuries, where arnica is not well borne: Excessive lachrymation in orbital neuralgia; pupils contracted; better during early morn, while sweating.—S. L., *California Homœopath*, December.

**INDICATIONS FOR CHININUM ARSENICOSUM IN NEURALGIA.**—Violent neuralgic pains in left mammary region, as though it were torn with red hot tongs; worse by motion and ascending; temporal or supra-orbital neuralgia.—S. L., *California Homœopath*, December.

**INDICATIONS FOR KALMIA LATIFOLIA IN NEURALGIA.**—Right side; pains at irregular times; continue for no definite period; come suddenly or gradually, and leave as uncertainly; pains in face burning, rending, agonizing; periosteal pains, worse by heat and sitting bent, better by cold and by standing up; albuminuria.—S. L., *California Homœopath*, December.

**INDICATIONS FOR TEREBINTHINA IN NEURALGIA.**—Neuralgia brachialis and sub-scapularis or supra-orbitalis: Worse at night; neuralgia vaga, with twitchings, as from electric shocks; worse from motion.—S. L., *California Homœopath*, December.

**INDICATIONS FOR VERBASCUM IN NEURALGIA.**—Violent jerking pains, or like crushing with tongs, caused by sudden draught of air, or by passing from the fresh air into warm room; regular quotidian attack (cedron), with considerable coryza and lachrymation.—S. L., *California Homœopath*, December.

**ANTIPIRYNE IN HEADACHE AND INFLUENZA.**—We abstract briefly from the November *Current Clinique*, the following: Mr. W., aged seventy-two, had imperfect digestion, and frequently severe headache in consequence. The pain was in the frontal region, and was aggravated by over-use of the eyes. As the attack proceeded, he got a tender spot on some part of the scalp, generally in the right frontal region. He had a vascular disturbance, with throbbing behind the right eye. Because the poisoning cases, in certain symptoms, showed a strong resemblance to migraine, an eight-grain dose of antipyrine was prescribed. The pain, which had been hard and continuous for two hours, was entirely gone in twenty minutes, and did not return for several weeks. Coincidentally with the cessation of the pain, there appeared a violent attack of sneezing, coryza and lachrymation. He certainly sneezed

twenty times without a pause. There was irritation of the larynx, coughing, tightness of the chest, difficulty of breathing and hoarseness. After the lapse of an hour these symptoms readily faded away, leaving him fatigued and indisposed to repeat that new headache remedy.

Mr. B., aged forty, presented himself, suffering with the same train of symptoms as had been produced in Mr. W. The suddenness of the attack, the wide extent of irritation, and the marked irritability of the mucous surfaces, suggested the use of antipyrine. That medicine was prescribed in five-grain doses of the first decimal trituration. As if by magic, the catarrhal storm was warded off, and the patient almost at once put in possession of his usual ease.

**NATRUM MURIATICUM IN SICK HEADACHE.**—"Mrs. P., seamstress, has a sick headache whenever she eats rich food. Attack commenced with dazzling in eyes, like lightning, which lasted half an hour, and ushered in a throbbing headache in the forehead and vertex, with nausea; can hardly hold her eyes open; feet cold, and great chilliness all over; occasional sour or bilious vomiting. *Natrum muriaticum*, 200. One dose cured."—Dr. J. C. Morgan, *California Homœopath*, November.

**THEA CÆSAREA IN PSEUDO-ANGINA.**—"A lady of forty suffers from sudden perversion of blood-supply in the medulla oblongata, with resultant cardiac distress, the latter evidently arising from increased vagal inhibition. These attacks, accompanied by acute dyspnoea, sudden formation of flatus, and intense sense of impending death, are quickly relieved by *thea cæsarea* 12. The lady is not a tea drinker. The remedy was selected, first, because of the sense of sinking at the epigastrium that precedes the attack; second, because of the profound anxiety that attends the seizure; and third, on account of the sudden production of wind in quantities."—Dr. Edward Blake, *Monthly Homœopathic Review*, October.

**SPIGELIA IN CARDIAC DISORDER.**—Dr. W. S. Bhaduri cured rapidly, with *spigelia*, after aconite, bryonia and digitalis had failed, a young man who had high fever, with an intense pain in the left side of the chest. There was no evidence of disease at the first examination. The pain was a fine stitch, increased by deep inspiration and change of posture; patient in great mental distress and screaming and crying; heart action tumultuous, visible to bystanders; difficult and labored respiration, almost suffocation. A pericardial friction murmur was now discovered, but there was no great amount of percussion dulness. *Spigelia* greatly ameliorated the condition within three hours. In two days the patient was able to sit in a chair. —*American Homœopathist*, December.

**ARNICA IN CARDIAC DROPSY.**—"J. B., aged sixty-nine, cardiac dilatation, hydrothorax and general anasarca, accompanied by the inevitable and distressing dyspnoea. The lower extremities were enormously distended and oedematous, and so sore that the touch of the finger caused severe pain. Felt bruised and beaten; 'ought to be black and blue,' as he expressed it. I determined to try *arnica*, to relieve the soreness, if possible, and prescribed it in the 3x. I was pleased to find the 'bloat' lessen gradually by copious urination, until, at the end of a week, the limbs had regained their normal size, the dyspnoea was gone, and no soreness or pain as before. Patient was able to lie down and sleep, and be out-of-doors, things he had not ventured upon for some time."—Dr. W. A. Wakeley, *North American Journal of Homœopathy*, November.

**ANTIPYRINE IN ASTHMA.**—Mr. W., aged fifty, mechanic, has had asthma nearly every night for three years. He had no bronchitis nor cardiac trouble, and but little emphysema. He would have one or two attacks every night, and occasionally one during the day. He had taken divers remedies from many physicians with no effect. Fifteen-grain doses of antipyrine were given at 5 P.M., 12 P.M., and 12 noon. The patient had only one very light paroxysm during this time. The same treatment was repeated on the following day with a still better effect. Five-grain doses were then given every three hours, during the four succeeding days, until the asthma had ceased. The medicine was then withdrawn. Some weeks later he reported no return of the paroxysm. The antipyrine was given because the prescriber had noted among the poisoning symptoms produced by the drug, severe fits of coughing, but unattended with expectoration; breathing hard and labored, accompanied by a feeling of suffocation and complete inability to lie down; extreme tightness of the chest and throat, with loss of voice and difficulty of breathing; great sense of suffocation, tightness of chest and wheezing cough.—*Current Clinique*, November.

**IGNATIA IN CHRONIC CATARRH.**—"Ignatia is a drug not generally recognized in chronic catarrh of the frontal sinuses and ethmoidal cells, but I have seen most remarkable effects from it when the distress centred just across the nose, between the eyes. It relieves the present distress of the patient and contributes largely to the cure of the chronic catarrh.—T. F. Allen, *Chironian*, November.

**AMBROSIA ARTEMISIFOLIA IN HAY FEVER.**—Dr. C. F. Millsbaugh, in the November *Homœopathic Recorder*, reports the cure of four cases of hay fever by the administration of *ambrosia* in the 3d centesimal.

**SENEGA IN COUGH, WITH SYMPTOMS IN THE BACK.**—Dr. St. Clair Smith tells of a spasmodic cough, in an elderly gentleman, who complained of a pain in the back, over the kidneys, a bursting, distending pain, as if the back would split with each paroxysm of coughing, cured with one dose of *senega* 3.—"Therapeutic Notes," *North American Journal of Homœopathy*, October.

**STAPHISAGRIA IN SPASMODIC COUGH.**—Dr. H. St. Clair Smith, with one dose of the 200th of *staphisagria*, cured Dr. B. of a severe spasmodic cough, excited by tickling in the larynx or trachea, accompanied by a bursting pain in the forehead, as if it would be torn asunder.—"Therapeutic Notes," *North American Journal of Homœopathy*, October.

**SOME REMEDIES OF SERVICE IN PRTHISIS PULMONALIS.**—Dr. Morrison, in the Bristol *Monthly Homœopathic Review* for December, mentions the following drugs: *Dioscorea* for spasmodic cough; *bryonia*, tincture to 3x, for bronchial and pleuritic symptoms; *arseniate of strychnine*, granules or 3x trituration, for depression of temperature and primary abdominal mischief; *lycopodium*, 12 to 30, for the latter effects of pneumonia; *sulphide of calcium*, granules or 3x trituration, for constitutional and germicide effects; *chamomilla*, tincture, for colliquative perspirations; *phosphorus*, 3x to 30, for congestive and acute pneumonic symptoms, and *quassine*, granules, for anorexia and furred tongue, and constriction of the intercostal muscles.

**KALI BROMATUM IN THE COLIC OF INFANTS.**—Dr. E. M. Hale, in the October *Medical Advance*, tells of quite a number of cases of colic in infants cured by varying potencies of *kali bromatum*.

**BRYONIA IN CHRONIC DIARRHŒA.**—Dr. C. F. Millsbaugh reports the cure with *bryonia* 30 and 200 of a diarrhœa of twenty years' duration. It was one of those bowel complaints that followed the camp fevers of the war.—*Homœopathic Recorder*, November.

**PODOPHYLLUM IN AN UNDIAGNOSED CASE.**—Dr. St. Clair Smith, in the *North American Journal of Homœopathy* for November, relates the following case: "Dr. — consulted me for a condition of ill-health which had come upon him each summer for several years, and for which he had tried various modes of treatment without avail. He was pallid, and complained of great lassitude, with disinclination for any exertion—physical or mental. The least physical exertion tired him out. His tongue was covered with a thick, yellowish fur, which looked like a layer of thick felt or chamois skin, breath exceedingly heavy and bad, no appetite, an abundance of gas in stomach and bowels, with frequent belching of bad tasting gas without relief. Constant diarrhœa, stools thin, not watery, nor copious, about the consistency of condensed milk or thick cream, and about the color of flour, gruel or pap, with a most atrocious odor. They were passed without pain. One dose of *podophyllum* 200 cured. He was better next morning.

**EUCALYPTUS OIL IN DIARRHŒA.**—Mr. W., aged forty-three, became wet, and for a week suffered from pains across the upper abdomen and a profuse, yellow, watery diarrhœa; no appearance of blood, but a little mucus; pulse, 100; temperature, 100° F.; tongue very foul, yellow and slimy. *Eucalyptus oil*, administered by Dr. E. M. Madden, cured.—*Monthly Homœopathic Review*, October.

**PHOSPHORUS IN CHRONIC BRIGHT'S DISEASE, WITH HEART SYMPTOMS.**—Dr. J. H. Freer was consulted by an elderly lady, whom he had previously treated for acute Bright's disease, with uræmic convulsions, for irregular heart action. Especially after fatigue her heart would become embarrassed in action, and she would have a sensation of suffocation, attended and followed by irregular and

tumultuous action of the heart. An examination of the urine microscopically discovered nothing abnormal save an abundance of oil globules. *Phosphorus*, prescribed on account of the presence of the oil globules, caused a disappearance of the cardiac symptoms.—“Therapeutic Notes,” *North American Journal of Homœopathy*, October.

**BENZOATE OF LITHIA IN DYSURIA.**—Dr. S. D. Johnson, in the September *Medical Current*, tells of a lady, twenty-eight years old, an invalid, who had a tormenting dysuria of long standing. There was “constant urging and severe pain at the completion of urination; the bowels were obstinately constipated; the urine was very highly-colored, and so intensely fetid that it had to be carried from the room.” *Benzoate of lithia*, 14 trit., gave prompt relief.

**MERCURIUS IN ACID URINE.**—A small child was brought to Dr. S. D. Johnson with the following history: Every time it urinated it would, shortly after, begin to cry, and would continue in evident pain, unless it was immediately washed off. *Mercurius 3x* relieved at once. Dr. Johnson also relieved with *mercurius* a lady who “had to wash the urine off, if it touched her anywhere about the vulva.”—*Medical Current*, September.

**REMEDIES FOR PUERPERAL RETENTION OF URINE.**—Dr. Sheldon Leavitt, in the September *Homœopathic Journal of Obstetrics*, in discussing the treatment of puerperal urinary retention, gives the following remedies:

*Belladonna*.—One of the best. Especially indicated in those cases where there has been a small loss of blood; considerable arterial tension.

*Aconite*.—When the woman has exhibited strong reaction from the strain of labor; moderately strong, rapid pulse.

*Arsenicum*.—Retention, unaccompanied with desire to urinate.

*Nux Vomica*.—Frequent or constant desire and ineffectual effort.

**ARSENICUM AND HYOSCYAMUS IN POST-PARTUM RETENTION OF URINE.**—“In retention of urine after parturition, with no desire whatever, arsenicum 3x seldom or never fails. If there is a desire, with some twitching of the muscles, hyoscyamus, 2x dilution, may relieve.”—Dr. S. D. Johnson, *Medical Current*, September.

**THE IODIDE OF LIME IN FIBROIDS OF THE UTERUS.**—“I have cured twenty-eight cases of fibroid tumors of the uterus, varying in size from a hickory nut to an infant’s head, with the iodide of lime, fifteen or twenty grains to the pint of water, which would give us about the second or third decimal dilution; one tablespoonful after each meal, for from three to twenty months has invariably cured these cases.”—Dr. Phillips, *Medical Era*, October.

**KREOSOTUM IN UTERINE DISEASE.**—“Mrs. A., aged twenty-nine, usually very strong, had not been out of her house in two years; fainted when asked by her physician to allow me to see her; very nervous; could not bear even the clothes of her bed touched. She had been treated (locally) fifteen months by one, and eleven months by another, old school physician. Her left arm was almost useless. She suffered from constipation, and had ulceration of the womb, with offensive leucorrhœa, that caused a burning sensation wherever it touched the skin. She complained most of a ‘ball of hot iron’ in the pelvis. Taking the latter symptom for a key-note, I found, out of the totality of symptoms, enough to warrant a prescription of *kreosotum*. Her recovery began at once. In five weeks she went shopping, and walked several blocks. Discharged cured.”—Dr. Juliet P. Van Evera, *North American Journal of Homœopathy*, November.

**SECALE IN PROLAPBUS UTERI.**—Dr. H. E. Deane, in the *British Monthly Homœopathic Review* for November, tells of a case of prolapsus uteri occurring in a multipara, in whom the womb was slightly enlarged and the vagina very flaccid. She complained greatly of pain in the back. *Secale cornutum 1x*, in five-drop doses, was prescribed. She felt some relief after the first dose, and in a fortnight could perform her household duties comfortably.

**SEPIA IN UTERINE DISEASE.**—Dr. Juliet P. Van Evera, in the *North American Journal of Homœopathy* for November, relates the following case: “A clergyman’s wife, aged thirty; black eyes and fair skin. With the aid of a speculum I found extensive ulceration of the os uteri, ichorous discharge, excoriating the vagina and

external parts; face brown with moth spots, especially the forehead; very dejected, never indulging in a smile. She was in a perfect state of health at the time of her marriage, and the beginning of ill-health dated back six months; from her marriage she had suffered with an unconquerable ambition to reach the altitude of her husband's grand ideas; she was morbidly jealous of his library, church, and everything else. The husband was distressed, unconscious of his part in the case. To cheer her, the more sparkling wit he gave to his jokes, the more ignorant and stupid she thought herself. *Sepia* cured."

**OXALIC ACID IN LUMBAGO.**—"Mrs. S., aged fifty-five years, had been suffering for five days with an excruciating lumbago, when she presented the following symptoms: Terrible pain in the lumbar region, extending down the thighs and over the region of both kidneys; extremely anxious to change position frequently, but the slightest movement, assisted or unassisted, caused her to shriek out in agony; frequent desire to pass large amounts of urine, but the pain on moving was so great that she would shrink from the attempt; legs numb and very weak and cold; pulse rapid; short, distressed breathing in general, though at times there were intervals of easier respiration; appetite normal, though swallowing was difficult and painful. I prescribed *oxalic acid* 30 in half hour doses, and had the pleasure of hearing that two hours afterward she could be placed upon the vessel with very little pain. She sat up twelve hours after, and in twenty-four hours was entirely relieved."—Dr. C. F. Millsbaugh, *Homœopathic Recorder*, November.

**ARNICA IN SCIATICA.**—A patient, aged sixty-four, consulted Dr. W. A. Wakeley during a severe attack of sciatica, to which he had been subject. He had the usual severe pain extending from hip to knee and occasionally shooting to foot, but in addition the limb felt bruised and beaten, and he was unable to bear even the pressure of clothing on it. "Felt just as it had once when kicked by a horse." *Arnica* 3x was prescribed, and two days later his sciatica (of six weeks' standing) was entirely gone, as was also the attending soreness.—*North American Journal of Homœopathy*, November.

**MERCURIUS CYANATUS IN DIPHTHERIA.**—In the *British Monthly Homœopathic Review* for October, Dr. T. G. Stonham reports the cure of seven cases of diphtheria with *mercurius cyanatus* 30. The cases were contagious, characterized by fetor of breath, rather low temperature, rapid pulse, and, in several cases, considerable prostration.

**AURUM METALLICUM IN SYPHILIS.**—Dr. S. H. Blake cured a man of thirty-five who suffered from constitutional syphilis, with sore throat, nodes on the skull, glandular enlargement, psoriasis and a warty excrescence on the prepuce, after iodide of potash, chloride and biniodide of mercury and phytolacca had been unsuccessfully employed, with *aurum metallicum* 3x.—*Homœopathic Review*, August.

**KALI HYDRIODICUM IN SYPHILITIC PHTHISIS.**—"An old man was affected with extensive and long-standing syphilis, the bones of the skull being very carious. He also had phthisis, evidently of syphilitic character, presumably syphilitic deposits in the lungs. There were thick, purulent sputa, together with the ordinary symptoms of phthisis. No remedy did good, though several pulmonary remedies were tried, until *kali hydriodicum* 1x was tried, then immediate benefit followed, and the lung condition was cured."—Dr. S. H. Blake, *Homœopathic Review*, August.

**MERCURIUS SOLUBILIS IN SYPHILITIC SUPPURATION.**—Dr. S. H. Blake, in the *August Homœopathic Review*, relates the following case: "A case of constitutional syphilis occurred in a man aged twenty-five, associated with suppurating local sores. The case was seen during the first outbreak, the sores being still present. The skin was extensively affected with a pustular eruption, very like small-pox, the pustules even being somewhat umbilicated, with red areola. *Mercurius solubilis* cured all in a few days."

**HYPERICUM IN PAIN.**—Deprecating the use of morphia in surgical cases, Dr. Gilchrist says: "Hypericum absolutely prevents pain in any kind of operation which is painful in nature. It makes no difference in what form you administer it, whether in the tincture, the thirtieth, or two-hundredth, the results are the same. I know that many think where there is any mechanical obstruction it is necessary to give an anodyne."—*Northwestern Journal of Homœopathy*, September.







W. B. Tinto

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THE ALBUMINURIAS OF PREGNANCY.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

II. DIAGNOSIS.

THE essentials in diagnosis are the following: First, to differentiate between *anorganic* (functional) albuminuria and *organic*; second, in cases of organic albuminuria, to distinguish between *renal* and *extra-renal*. I limit the term "renal" to lesion of the renal substance proper, and do not include that of the collecting portion of the kidney.

Careful diagnosis is necessary, first, for prognosis; second, as a guide in treatment.

Ten years ago, I began the crusade for twenty-four hours' urine, and with such success that it is now the rule rather than the exception for patients to comply with a request for the total quantity passed in a day. It is particularly necessary in pregnancy that twenty-four hours' collections be repeatedly made; in order to facilitate matters, I have devised a method for such collections which I hope will become as popular elsewhere as it is among those to whom I have already recommended it.

JUST HOW TO COLLECT THE URINE OF TWENTY-FOUR HOURS.

Begin the collection on *Sunday* morning, if it is inconvenient to do so on week-days. Use the following apparatus (see Fig.):

A, receiving vessel; the most convenient is a neckless glass pitcher, six inches or more in diameter at its widest part. *Rinse out with scalding water* before voiding urine into it. Invert and let drain; *do not wipe out with dirty cloths.*

B, a clean glass bottle, holding about half a pint.

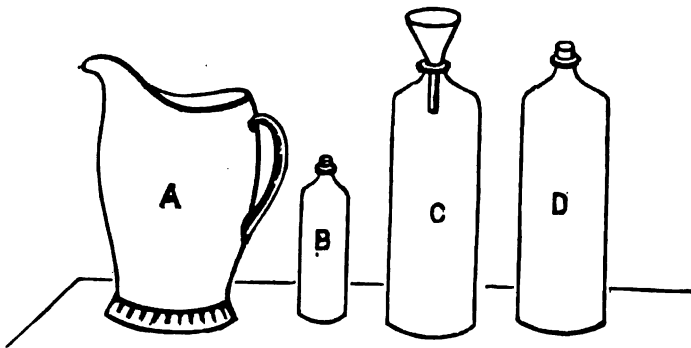
C, a clean quart bottle for the day-urine.

D, a clean quart bottle for the night-urine.

The patient rises Sunday morning, empties the bladder thoroughly, not saving the urine thus voided. *But from after breakfast on*, all urine is to be saved. All urine is to be voided into the pitcher, A, and on no account into a chamber-vessel.

Pour the urine thus collected in vessel A into bottle C, using a glass funnel. All day long on Sunday void urine into vessel A and transfer to bottle C, as before, corking tightly with clean rubber cork. Urine voided during the evening, *before* going to bed, should be included with that in bottle C.

On the other hand, all urine voided during the night, and *that which*



*is voided on rising Monday morning*, should, after collection in vessel A, be poured into bottle D, and corked tightly as before. Next, label bottle C "Day-urine," and bottle D "Night-urine." Lastly, collect and pour into the *small* bottle B, thus far not mentioned, the urine voided on Monday at about noon or early afternoon, or at any time when the patient has been taking the most exercise. Women, before voiding urine for bottle B, should, if possible, take a cleansing injection. If the urine is to be sent out of town, add to that in each bottle one-hundredth its volume of chloroform. If these directions are complied with, the physician obtains (1) the day-urine, (2) the night-urine, (3) a sample voided after most vigorous exercise. *Never collect urine in the ordinary chamber-vessel.* The glass pitcher which I describe costs but twenty-five cents, and can be kept entirely for the use of the patient himself, is easily and thoroughly cleaned, and in every way is more desirable than the relic of barbarism which, for centuries, has been in vogue. I hope, before many years, to become

so imperious in my urinary sway as to refuse either to look at or to examine urine which has been collected in the ordinary household vessel.

Urine collected in the manner which I have described is free from micro-organisms, save those from the patient himself. It keeps fresh longer, because from beginning to end of the collection every precaution in regard to cleanliness has been observed.

[I claim, by means of my method described, to find tube-casts in cases where competent observers have previously reported "no casts." The reason is simple: When *some* urines are collected in a chamber-pot they soon become turbid from presence of micro-organisms. This is particularly true of the urine of women. The turbidity does not readily settle, and the casts have no chance to collect at the bottom of the glass, being suspended in the mucus-cloud throughout the urine. It then becomes a matter of chance whether the physician finds them or not. Second, if a cleansing injection is not taken by women before urine is voided there is often such a mass of mucus, epithelial cells, and, in cases of leucorrhœa, purulent admixture from the vagina, that a few hyaline and finely granular casts may be completely hidden from view. Moreover, colonies of bacteria and masses of granular matter may be mistaken for casts and a direful prognosis given, when a vaginal discharge is responsible for the whole.]

#### HOW TO MEASURE THE TWENTY-FOUR HOURS' URINE.

Measure first the day urine; second, the night urine. Use a graduate, and whichever measure, American or French, is most familiar. Fluid ounces may be converted into cubic centimetres by multiplying by 30.

Compare the quantity of day-urine with that of the night. Day-urine should, in health, exceed the night-urine in volume.

I subjoin a number of measurements of day- and night-urine, which I have made in cases of renal lesions:

	Day, c.c.	Night, c.c.
Sub-acute diffuse nephritis, . . . .	740	710
Chronic " . . . .	720	1260
" " . . . .	750	780
" " . . . .	720	1410
" " . . . .	780	750
" " . . . .	750	650
" parenchymatous nephritis, . . .	330	380
" diffuse nephritis, . . . .	900	350
" " . . . .	550	450
" " . . . .	650	400
" parenchymatous nephritis, . . .	156	360

In all eleven of these specimens albumin and tube-casts were found. It will be seen that in *four* of the cases the night-urine exceeded the day; in *five* cases the quantities were about equal; in *two* cases the day-urine exceeded the night-urine by 250 cubic centimetres or over.

The following list shows a number of cases, not renal, and in which neither albumin nor casts could be found:

	Day, c.c.	Night, c.c.
Melancholia, . . . . .	830	500
Neurasthenia, . . . . .	660	240
Diagnosis unknown, . . . . .	500	220
Inflammation, neck of the bladder, . . . . .	700	380
" " " . . . . .	1050	300
" " " . . . . .	650	300
Neurasthenia, . . . . .	660	240
Inflammation, neck of the bladder, . . . . .	660	270
Nervous prostration, . . . . .	390	180
Diabetes decipiens, . . . . .	360	260
Renal calculus, . . . . .	320	340

In these eleven cases there is only one in which the night-urine exceeds the day, and in that case the condition was, so far as I can find, due to renal calculus, history of renal colic, etc.

I add four more measurements in cases of renal inadequacy, three of them in a case in which I find occasionally hyaline casts and a trace of albumin, but sometimes neither. The other in a case of what appears to be paroxysmal albuminuria:

	Day, c.c.	Night, c.c.
Renal inadequacy with occasionally casts, . . . . .	940	720
" " " " " . . . . .	980	360
" " " " " . . . . .	1055	320
" " " " albumin, . . . . .	540	420

These last two cases may be set down as doubtful; time is needed for a diagnosis.

The conclusion to be drawn from these measurements is that while it may be possible to find albumin and casts in cases in which the day-urine considerably exceeds the night, *it is certainly advisable to examine thoroughly the urine in all cases of pregnancy when it is found that the day-urine is either less than the night or but little in excess of it.*

In my next paper I shall explain more fully the points which, in my mind, distinguish organic albuminuria from merely functional disturbance, and second, true albuminuria (lesion of the renal substance) from false lesion of collecting and conducting portions of the urinary tract.

## THE SEQUELS OF TYPHOID FEVER.

BY G. MAXWELL CHRISTINE, A.M., M.D., WITH NOTES ON A CASE BY  
HORACE F. IVINS, M.D.

(Read before the Philadelphia County Homœopathic Medical Society, October 10, 1889.)

DURING, or shortly after, convalescence from typhoid fever, there will occasionally occur disease-manifestations bearing to the original disease the relation of effect to cause. These results are known as sequels. Respecting scarlet-fever and diphtheria, these untoward results have been fairly well studied and are generally well comprehended. The sequels of typhoid fever do not, however, seem to have engaged quite the attention which their importance demands. The remark of frequent utterance among the laity, and occasionally among the profession, that a patient having typhoid fever will, if he recovers, be the healthier for having had the disease, needs considerable qualification, for in many instances the gravest possible conditions supervene on the subsidence of the fever.

In his "Toner lecture," Dr. W. W. Keen has exhaustively considered the surgical complications and sequels of typhus and typhoid fevers. To those physicians who have not read this lecture, or who have not paid special attention to this subject, Dr. Keen's article will furnish much valuable information. This author shows that diseases of the joints, œdema glottidis and necrosis of the cartilages of the larynx, gangrene of the extremities and other parts, fistulæ of various kinds, etc., are the surgical sequels most apt to occur after these fevers.

What is probably the best existing general consideration, from a medical standpoint, of the sequels of typhoid fever, is given by Dr. James C. Wilson in his estimable work on "The Continued Fevers." This article is likewise well worth a careful perusal.

In addition to these two references there are to be found here and there among medical books and journals other references of a more or less complete character, though none perhaps so thorough as those of Keen and Wilson. At the close of Dr. Keen's lecture will be found a large list of references to the literature on the subject of surgical sequels, but I know of no published medical list of like nature. Homœopathic medical works do not seem to contain much on the subject. I account for this partly on the ground that the homœopathic physician does not surcharge his patient with devitaliz-

ing medicines, and therefore does not so frequently meet with sequels as to regard it of sufficiently great importance to record his observations. On the other hand it is certainly true that the allopathic physicians are not so successful in curtailing or curing this disease as is the homœopathist, and that therefore the 'former more frequently meets with sequels and is called upon more often to write concerning them. In the allopathic practice many of the complications and sequels occurring result from the heroic character of the treatment. Though the homœopathic physician is ever ready to administer remedies in sufficiently large doses to cure the disease, the charge can not be laid at his door of forcing the action of medicines beyond their necessary degree of action. Homœopathy seeks to act upon the disease and then to withhold drug action, so that such parts of the system as are not affected by the disease will not be altered functionally or organically by the drug. Allopathy as practiced by the "old school" has not in the past observed this rule, and what little of it is observed to-day by them has been copied, without due credit, from homœopathy.

Complications and sequels occurring in the practice of homœopathic physicians are necessarily the result of some other cause than over drug-action. Accusations have been brought against the homœopathic physician of virtually administering no medicine at all, which, if it were true, would, we admit, account for the existence of some of the typhoid complications and sequels. Admitting, for a moment, this unfounded impeachment be true, the advantages of no treatment at all over the heroic treatment of the allopathic school, in such diseases as typhoid fever, are so manifest that the indictment fails to be of any force. They cannot even accuse allopathy of being responsible for all the complications and sequels which may occur in the course of, or following, the disease which it is treating. For independent of the want of action, or of the over-action, of remedies, there appears to be a disposition on the part of the fever processes to set up changes of nutrition in the various parts of the body. Nor is it strange that such should take place, in view of the fact of the great tension under which the system of a typhoid or typhus fever patient is being constantly held. There are fevers in which the temperature reaches a higher point, but none in which for so long a time it is kept so high. In this respect, typhoid and typhus fevers are unique. The prolongation of a very high fever over a period of three or more weeks, with the consequent weakening of the heart and circulation, severe nervous strain, intense gastric and intestinal dis-



turbances, frequent pulmonary, renal and other complications, constitute an array of active morbid processes not equalled, in kind or degree, by any other fever.

Under this severe tension not only do the various organs of the body become perturbed in function, but the various tissues become the seats of slow inflammatory changes, the powers of resistance are weakened, and that which in health and in most diseases can make no impression now is enabled to give rise to congestion, catarrhal and other inflammations, ulceration, embolism, etc.

Wilson says that the complications and sequels of typhoid fever fall into two classes: The first of these comprises those which are due to an unusual development of the pathological processes of the fever; the second, those occurrences not necessarily dependent upon the malady, but to which the condition of the patient renders him liable. In the first class Wilson includes perforation, peritonitis, rupture of the muscles, abscesses, parotitis, nephritis, various affections of the nervous system, venous congestions, hypostasis, œdema, thrombosis, embolism, infarction, etc. In the second class are included pneumonia, pleurisy, erysipelas, diphtheria, etc. This author then reviews in succession the following complications and sequels:

Œdematous laryngitis, ulcerative laryngitis, and perichondrial laryngitis; necrosis of the nasal cartilages, bronchial catarrh, hypostatic congestion of the lungs, œdema of the lungs, hæmorrhagic infarcts, lobar pneumonia, acute miliary tuberculosis, pleurisy, dilatation of the heart ventricles, endo- and peri-carditis, ulceration of the tongue and of the buccal mucous membrane, catarrh of the mucous membrane of the pharynx and posterior nares, swelling of the parotid glands, jaundice, transitory albuminuria, hæmaturia, catarrh of the bladder, profuse or premature menstruation, herpes labialis, facial paralysis, hæmorrhages into the skin, boils and abscesses, bed-sores, alopecia, malformation of the nails, effusion of blood, meningitis, feebleness of the intellect and attacks of mania, palsy, neuralgias and disturbances of sensation, deafness, paralysis of accommodation, amblyopic conditions, sloughing of the cornea, anæmia.

This list of sequels of typhoid fever is more than sufficient to indicate the wide scope of the divergences from the direct course of the disease that happen more or less frequently. Some of them are dependent upon actual tissue alteration, whilst others are consequent on an inability on the part of the system to make up for tissue waste. But, in addition to the general influence which the typhoid poison has upon the system, it evidently predilects a locality for the

expenditure of its force, which locality soon becomes the seat of atrophic and other changes. Lesion of the solitary and agminated glands is, of course, a constant factor in typhoid fever. This makes the name "enteric" a more appropriate term for the disease than is "typhoid." But objections to this term have been urged on the ground that the intestinal lesions are sometimes secondary in gravity to those existing elsewhere as a result of the typhoid poison; and again, that Murchison was not correct in his statement that the agminated and solitary glands of the ileum are constantly and invariably diseased in typhoid fever. These objections seem, at first sight, to be valid,—the more so when it is borne in mind that often intestinal symptoms are very mild, while symptoms referable to other parts of the body are markedly severe, and that sometimes symptoms of intestinal lesion defy detection, the latter being demonstrable only *post-mortem*. All available evidence on the subject indicates that typhoid fever has a "definite anatomical lesion," and that its *loco in citus* is in the intestine. But what is the *rationale* of those cases which, as we have said, give rise to doubts that this is so? The explanation is as follows: The agminated and solitary glands of the ileum officiate for the rest of the body as guardians against the introduction of the typhoid poison. On its entrance into the intestine the poison finds that its further progress into the system is, in part or in whole, checked. If the amount of the poison is great and its virulence active, we find the intestinal symptoms proportionately prominent; but if the poison has been received into the bowel in small quantity, and its virulence moderate, the intestinal lesion is correspondingly mild; or the guardianship of the glands may be insufficient, and the poison thus finds it not a difficult matter to elude their vigilance. Other parts of the body then become the seat of the typhoid ravages, in which case the intestinal symptoms are subordinate. This is probably the true explanation as to why certain cases of typhoid fever of short and calm duration, so far as the intestinal manifestations are concerned, have serious complications, or are quickly followed by grave and fatal sequels.

Coupling this theory of the cause of complications and sequels with that already given in the fore part of this paper, we have their causation satisfactorily comprehended.

Two questions of vast import are: Can we prevent complications and sequels occurring in typhoid fever? Will typhoid fever ever be robbed of the tendency it has to elude the vigilance of the phy-

sician whose science, art and care are each exercised to keep the action of the poison within the bounds of its characteristic sphere?

I will not attempt to answer these questions, except in a general way. As has been before stated, typhoid fever is more easily and certainly cured by homœopathic treatment than by that of the "old-school,"\* which fact already gives a fair answer to the questions propounded. But even the most zealous homœopath will certainly not lay claim to a perfect immunity from sequels in typhoid fever, even under his most approved treatment; for, as we have pointed out, there are sequels, as well as complications, which are independent of the character of the treatment, but which have a direct relationship with the activity of the typhoid poison or the weakness and susceptibility of the system affected.

The appropriate use of medicine and the required administration of nutriment will do much to ward off a large percentage of these undesired results. The early recognition of side-symptoms and the institution of the indicated treatment will often check them in their incipency.

No case of typhoid fever can be considered out of danger or cured until a long period has elapsed after the decline of the fever. The length of this period is not a fixed quantity, but differs in each case. During the active course of the fever, as well as during convalescence, the utmost watchfulness should be exercised for the detection of complicating, intercurrent and accidental events. "The eye should seize upon any hindered movements, even without pain, and no com-

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\* SIGNIFICANT FIGURES.—Those who think that homœopathy has no further victories to win are invited to consider these statistics, taken from the *Homœopathic World*. The recent typhoid epidemic at Melbourne afforded an opportunity for comparison of results at the different hospitals. We will give the figures of the three principal hospitals for the first three months of the year 1889:

	No. of beds.	No. of typhoid cases.	Deaths.	Percentage.
Melbourne Hospital, . .	318	431	78	18.1
Alfred Hospital, . . .	144	324	50	15.4
Homœopathic Hospital, .	60	305	22	7.2

Less than half died under homœopathic treatment than there did under allopathic, and, more than that, the patients were ill a much shorter time; for the Homœopathic Hospital, with its sixty beds, was able to treat almost as many patients as the other hospitals, with five times the amount of accommodation in the case of the Melbourne, and more than twice the amount in the case of the Alfred Hospital. How our allopathic friends will evade these facts is not known. The comparison is perfectly fair, and the legitimate conclusion is that homœopathy cures twice as many cases of typhoid fever as allopathy does.—*North Amer. Journ. of Hom.*, September, 1889.

plaints of pain should fall upon a deaf ear, especially if it be in the throat, the belly-wall, the buttock, the hip-joint, the eyes or the toes. It may be the vagaries of a wandering mind. But it may also be, as we have seen, the herald of the greatest dangers, whose attacks may be entirely repelled or their force broked by heeding this timely warning."—(*Keen.*)

The following two cases are given to illustrate two forms of sequel. The one followed an attack of typhoid fever of unusual severity; the other followed closely on one of short and mild duration. The first is a not very rare form of sequel; but the second is very infrequent.

*Periostitis.*—Mrs. R., æt. 27, resident of Philadelphia, was taken ill at Atlantic City with what, for a time, it was difficult to differentiate between tuberculosis and typhoid fever. The diagnosis of typhoid fever was finally established, and the case was subsequently transferred from the care of an allopathic physician of the place to a homœopath. I remained the consultant with the second physician.

Delirium, angina pectoris, coccygodynia, cystic and urethral irritability, ulceration of the lower bowel, and other complications account for this long duration. During convalescence, which was rapid when it finally set in, there began the formation of a node on the anterior aspect of the tibia and one on a rib of the right side. The pain and swelling soon became very marked. Calc. fluor. was administered until a sinus opened, when the remedy was changed to silicea. At this writing, the leg is thoroughly well and the rib is fast becoming so.

#### LARYNGEAL TUMOR, PARALYSIS OF THE ABDUCTORS OF THE VOCAL CORDS.

CASE No. 2.—George P., æt. 18, came to my office on March 28th with headache, vertigo, and sore throat; pulse rapid, fever high and pains in the knees and arms. Diagnosis: Herpes of the tonsils.

Next day, he again came to the office with the herpetic eruption fully developed, more fever and higher pulse. No symptoms of diphtheria, and apparently none of typhoid fever. The following day I went to see the patient at his house, and found him with the throat symptoms greatly relieved and the herpetic eruption better. In the evening the temperature was higher—104° F.—and the bowels were loose. There were also tympanites, delirium, dry and brown tongue, and nose-bleed. The temperature reached the maximum of 104° on the 1st of the month, and remained at that point for two days and then began to decline until the evening of the 15th, when the fever entirely disappeared. At no time was the pulse above 108, and then only for two days, after which it was always below 100, and generally below 95. The delirium and diarrhœa were

moderate. The patient recovered quickly from the typhoid fever proper, and by the 1st of May was able to walk readily from room to room. Recovery seemed complete. On the evening of the 1st, however, a cough of a croupy nature set in, accompanied with marked irritability of the larynx and pharynx. Causticum, at one time, and bryonia at another, relieved this symptom for a day or so, but there was soon a return of the cough in an aggravated form, this time associated with marked dyspnœa on inspiration, increased difficulty in swallowing solid food, hoarse voice and mucus expectoration. There had been marked stridor in sleep. The laryngoscope showed marked congestion of the walls of the larynx and of the bands, with almost total closure of the glottis on both inspiration and expiration. Owing to the condition of the patient, it was impossible for me to get more than a very imperfect view of the lower portion of the larynx. The epiglottis was not affected, and the larynx was clear of obstruction down to the cords. I hesitatingly made a diagnosis of acute laryngitis, with possible œdema of the cords, or an abscess in their vicinity, causing the closure of the glottis. That there might also be an element of paralysis in the case did not escape my attention. Remedies were unavailingly tried, and it soon became apparent that the patient must suffocate if relief did not soon come to his aid. On the morning of the 4th I summoned Dr. C. M. Thomas, in consultation, with the request that he come prepared to introduce the tracheotomy tube. Dr. Thomas complied, and in the afternoon operated under cocaine. Immediately on the introduction of the tube the symptom of dyspnœa subsided. No complications retarded the recovery of the lad from the effects of the operation. On the 14th Dr. Horace F. Ivins was called into the case. Between the date of the operation and the first visit of Dr. Ivins the laryngoscope was not used. Dr. Thomas and I had agreed to rest on our diagnosis of bilateral paralysis of the abductors of the vocal cords, and to be content for a couple of weeks to allow the boy to regain his strength before treatment was directed to the paretic or other existing conditions. Dr. Ivins agreed with the diagnosis of paralysis, but was enabled to see a growth of a polypoid appearance attached to the right ventricular band, and blocking up the posterior portion of the glottis. It was evidently this growth which, under the difficulty attending my examination prior to the tracheotomy, I mistook for a stenosis from œdema or abscess.

I will now permit Dr. Ivins to describe the condition in which he found the lad, and to comment fully upon the case. Prior to the treatment instituted by Dr. Ivins for the removal of the tumor, I had considerable difficulty with a muco-sanguino-purulent discharge, which soon so blocked up the outer tube, in spite of the exercise of great care, as to nearly strangle the patient before I could reach him. I had also to contend with an existing or a probable forming perichondritis. It afforded me the greatest pleasure to soon

notice the gradual decline and the final total disappearance of the symptoms which, for a while, it was feared were those of cricoid necrosis.

#### REMARKS BY DR. IVINS.

On the 15th of May, at the request of Drs. Charles M. Thomas and G. Maxwell Christine, I examined Master P. As already stated, the tracheotomy tube, through which the patient breathed freely to the exclusion of the natural passages, was in position. Respiration through the larynx was impossible for one minute, even with the greatest effort. The voice was practically lost, though upon forced expiration with closed, fenestrated canula the young man was able to speak two or three words in very rough, sepulchral tones, similar to those heard after total extirpation of the larynx when the voice is produced by the vibration of folds of adventitious mucous membrane and not by the vocal or even the ventricular bands.

The laryngeal mirror presented a very marked picture. The epiglottis, ary-epiglottic folds, and supra-arytenoid cartilages appeared normal; the left ventricular band was swelled, and by its size prevented a view of the corresponding vocal ligament; the right false vocal band was in the same thickened condition, and likewise hid the true one below it. In addition there projected from the free edge of the right ventricular band, near its posterior extremity, a little pedunculated, polyp-like mass about the size of a large pea. On account of the swelling it was impossible to see the glottic opening, but during vocalization and forced inspiration the ventricular bands vibrated sluggishly.

The condition was evidently inflammatory, but it was not easy to determine the exact pathological changes, for the absence of fever and of pain in the laryngeal region—the latter not resulting even from firm pressure—seemed to contradict the other indications of perichondritis. The inflammatory condition was quite sluggish and there was no oedema; on that account oedematous laryngitis could be excluded. There was neither bloody nor purulent discharge either from the larynx or trachea to indicate the presence of ulceration, but the granular mass suggested a past abrasion, or ulceration of the surface, or the existence of a sinus. The possibility of the mass representing a non-suppurative papilloma was not overlooked. The absence of pain and rise of temperature and the bilateral nature of the swelling did not indicate abscess formation.

It was decided to give ferrum iodatum internally, and to make applications of iodide of glycerine locally.

On the 20th the condition had improved slightly, the swelling of the ventricular bands had decreased, and breathing with closed canula seemed slightly less laborious. The polypus was about the same.

On the 28th the slight improvement noted had disappeared and the larynx presented well-marked tenderness to pressure. Internally the right side of the larynx was evidently more swelled, the arytenoid on that side appeared puffy, but the polypus was smaller. A diagnosis of perichondritis now seemed quite easy; suspicion pointed to the right arytenoid and to the plate of the cricoid. The internal remedy was changed to hydrastin mur., owing to a very abundant, bloody, muco-purulent discharge from the canula. Under the influence of this remedy the discharge soon ceased. The local applications of iodized glycerine were discontinued on account of the annoyance and irritation to the patient.

On the 18th of June the severe symptoms had nearly passed away; respiration was easier, and the voice a little stronger. The polypus was smaller, and decrease in the swelling of the ventricular bands made it possible to see the edges of the congested vocal ligaments anteriorly; the arytenoid had resumed its normal form. I did not see the case again until the 29th of August, when there was neither pain, tenderness, fever, nor cough; the voice was still rough and deep; laryngeal respiration was stridulous and only possible for a couple of minutes. The mucous membrane was nearly normal in color, with some congestion of the vocal bands. Anteriorly the latter separated somewhat during inspiration and approximated fairly well during vocalization. The evident motion of the vocal bands and arytenoid cartilages rendered improbable crico-arytenoid ankylosis. The one condition which masked the others and which assumed chief prominence was the presence of a large, gray, granular—papillomatous (?)—mass about as large as a cherry. It filled the posterior two-thirds of the laryngeal vestibule, rested on, perhaps between, the vocal bands, and reached to the summits of the cartilages of Santorini, and to the upper level of the ary-epiglottic folds.

On the first day of September a series of probings was instituted for the purpose of accustoming the interior of the larynx to the presence of forceps. By the 14th the larynx was sufficiently insensitive, with the aid of cocaine, to permit the removal of two small pieces of the growth, but the latter was so large that the tube forceps would not grasp it, and the larynx was not tolerant of larger instruments. On the 17th, with the aid of Fouvel's antero-posterior

forceps, the neoplasm was removed in four large pieces. The combined mass measured 11 mm. (nearly seven-sixteenths of an inch) in diameter. Respiration and vocalization improved at once.

On the 8th of October there was no indication of a return of the neoplasm; the vocal bands were still congested, but moved very considerably, although they could not be separated more than three lines even on forced inspiration, leading to a confirmation of the original diagnosis, viz.: abductor paralysis. From beneath the vocal bands the mucous membrane projected on each side; a probable inflammatory thickening of this tissue over the body of the vocal muscle, or an hypertrophy of the muscle itself. On account of this, iodine and glycerine were used locally and ferrum iod. internally.

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#### THOUGHTS ON MEDICAL LEGISLATION, AS SUGGESTED BY THE RECENT DECISION OF THE SUPREME COURT OF ALABAMA.

BY H. M. PAINE, M.D., ALBANY, N. Y.

THE discussion of the subject of medical licensure has recently received a new impetus by the outrageous conduct of "our friends, the enemy," in Alabama.

It appears that the allopathic school has had complete control for a number of years of the examination and licensing of all physicians who desired to practice medicine in that State. Nearly all the old-school physicians in the State, more than seventeen hundred in number, have complied with the requirements of the law. Fifteen, however, refused to submit to an examination. Among them two were homœopathic physicians, both graduates of homœopathic medical colleges. The trial of one of these, Dr. G. G. Lyon, has been set down for the 21st of January.

An old-school physician, a Dr. Brooks, was at first convicted by the Circuit Court, but on appeal to the Supreme Court was acquitted.

Dr. Brooks having been acquitted, in all probability the indictment against Dr. Lyon will be quashed, and neither he nor Dr. Meyers will, for the present at least, be hampered by the officious interference of illiberal allopathic physicians.

Notwithstanding this temporary suspension of allopathic antagonism, the cases of these two reputable homœopathic physicians, graduates of homœopathic medical colleges indorsed by the Ameri-



can Institute of Homœopathy, are invested with more than ordinary interest to the homœopathic medical profession throughout the whole country.

Their courageous resistance to allopathic oppression should receive our hearty approval, and their trials and hardships, endured in behalf of a common cause, should awaken on our part responsive sympathy, and, if need be, the bestowal of contributions sufficient to defray the expense incurred thereby.

In this instance these two young physicians are not by any means the *only* sufferers from allopathic intolerance and high-handed illiberality, wrought ostensibly under cover of justice and in behalf of public interests.

The welfare of every homœopathic physician in the whole country is jeopardized by this Alabama experience. Their failure will render more difficult attempts on our part in other States at checking allopathic aggression; and their success will assist in establishing a precedent in support of the proposition, recognized since the foundation of this government, that each school and system in medicine, as in religion, shall have entire freedom in the exercise of the *civil* functions having relevancy to the management and maintenance of its own educational affairs.

For these reasons it is desirable to notice in connection with these cases two of the more important points.

One is, the fact that Dr. Brooks escaped on a mere technicality, viz., that the civil and penal codes were not "co-extensive" in their "provisions," a conflicting condition which was inadvertently introduced during a recent revision of the code, and one which unquestionably will be speedily amended.

The other important point to be noted is, that the *right of the State to control medical practice by country and State authority is most emphatically affirmed.*

Dr. Cochran, State Health Officer, as reported in the *Birmingham Age-Herald* of December 28, 1889, states:

"The decision of the Supreme Court sustained the law all the way through, but construed away the penalty for its violation. It says, in effect, that Dr. Brooks has no right to practice medicine in Alabama on a mere diploma without a certificate from the regularly constituted examining board; that he is in violation of law, but that there is no penalty attached to such violation; in short, that the law is all right, but there is no way to enforce it."

Judge Stone in his decision, as reported in the *Montgomery Adver-*

tiser of December 17, 1889, expresses his opinion in the following forcible utterances:

"That the State, under its *police power*, clearly possesses the power to prohibit any person from practicing medicine without a license, or other test for ascertaining the qualifications and fitness of the applicant. That this power is supported by the same principle as that which justifies 'quarantine, compulsory vaccination, sanitary sewerage and many forms of public nuisance.' It is a mere agency for protecting the public against the dangers of charlatanism or quackery in medicine; and

"That this power is lawfully lodged in the medical boards of the State, and it is no objection that the law goes into effect upon the contingency of medical county boards organized in the counties. Local option laws are made operative upon precisely the same principle."

The judge held, substantially, that, while the civil code required compliance with a *single* provision, viz., a *license* from a county board, the penal code did not hold a physician liable if he had complied with either one of *four* provisions, viz., a license; a diploma; a certificate of qualifications; or, being a regular graduate of a medical college in Alabama, his diploma being legally recorded. Dr. Brooks having obtained a diploma from a regular medical college in Georgia, and his diploma having been recorded by the judge of probate of Russell County, he "had violated no law of the State which subjected him to a criminal prosecution," hence, "the judgment of the Circuit Court" was "reversed and the defendant discharged."

The position of the leaders of the allopathic school having been greatly strengthened as to the most important provision of the law, viz., *the right to establish State medical licensure*, under its "*police regulations*," the adjustment of a penalty, more or less severe, will surely and quickly follow.

The homœopathic medical profession of this country are, by this, the most recent decision bearing on this subject, brought *face to face with the fact*, that the allopathic school is vigorously prosecuting the work of establishing *State medical licensure*, State by State, in this country, and that the decisions of the highest State courts sustain the principle underlying such action.

The vital question, therefore, for homœopathic physicians everywhere to determine, and decide with as little delay as possible, has relevancy as to whether the allopathic school shall *monopolize* the exercise of this civil privilege as is now being done in Alabama, and

a few other States, to the serious detriment of our school, or whether, in this readjustment of medical affairs, precisely the same civil rights and privileges of medical licensure shall be extended to the representatives of the homœopathic school as are given to those of the allopathic.

We have not a moment to lose in dallying with questions as to whether this particular form of State supervision is wise, needed, or expedient. It is surely coming. It has been already established in several States. Its propriety and suitableness has already been sustained by decisions of the highest State courts.

Hence, the only alternative for our school is that of entering upon the work of procuring the passage of laws providing for State boards of examiners for *each* of the incorporated schools of medicine, and this work should be immediately inaugurated by the committees on medical legislation of each State homœopathic medical society.

Let the leaders of the homœopathic school in each State at once actively enter upon the work of securing provisions of law by which the examination and licensing of homœopathic students shall be *wholly conducted under homœopathic auspices*.

The American Institute, in 1887, 1888 and 1889, adopted resolutions endorsing such action in strong and forcible utterances, and similar sentiments have been repeatedly adopted by large numbers of State and local homœopathic medical societies.

If, in any State, an effective organization cannot be maintained, on account of fewness of numbers of homœopathic practitioners, residing at widely-separated localities, efforts can and ought at once to be made for securing homœopathic representation in existing allopathic boards, the homœopathic representatives thereof *to have the same powers and privileges in the board over homœopathic applicants as the allopathic representatives have over allopathic applicants*.

An amendment, providing for homœopathic membership in the allopathic board, was carried through the legislatures of Delaware and Florida last winter. As a result, notices of meetings for examining homœopathic applicants for license are now published in these States.\*

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\* "NOTICE TO PHYSICIANS.—

"JACKSONVILLE, FLA., November 29, 1889.

"Office of the Board of Homœopathic Medical Examiners in and for the State of Florida:

"In accordance with an Act, entitled 'An Act to Regulate the Practice of Medicine,' etc., approved May 31, 1889, notice is hereby given that said Board will meet

Let other States, following in their lead, take the matter immediately in hand, and push it to an early completion.

The reason why the homœopathic physicians of Alabama are now put to severe straits is simply because they have allowed the allopathic leaders to obtain complete legal control of the *civil right of licensure*. The people will extend this legal privilege to both schools alike, if asked to do so. The people most assuredly will extend to the different schools and divisions of the medical profession equal civil privileges upon the same principle as they now confer upon each of the different religious organizations the right to license and ordain applicants for religious orders. In order to acquire the right to exercise this privilege, the homœopathic physicians of that State must apply for it, and make application with such force and persistence as to secure it.

All praise should be given to Drs. Lyon, Meyers and Henry for the noble stand they have taken. If they are in need of funds for securing requisite counsel, homœopathic physicians in other States will unquestionably contribute pecuniary aid.

Circulars and arguments bearing on all the points relating to this important subject, prepared by the Committee on Medical Legislation of the New York State Homœopathic Medical Society, will be freely furnished by myself as chairman.

The writer will be glad to obtain the names and addresses of the members of the Committee on Medical Legislation of all State and local homœopathic medical societies, in order that each may be supplied with copies of circulars stating at length the reasons for entering upon this work with alacrity and zeal. In case bills are introduced into any of the State legislatures by the allopathic school, providing for the appointment of a *single* board, it is very desirable that he should be informed thereof, and that one or more copies of the proposed bills should be immediately mailed to him.

In a letter dated January 1, 1890, Dr. J. H. Henry, of Montgomery, Ala., urges the immediate inauguration of measures for collecting a medical legislation fund of \$10,000 to be used in antagonizing the formation of the *gigantic monopoly* of medical licensure

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in Jacksonville, December 30th, at 10 A.M., and will remain in session two days, adjourning at 10 P.M., December 31st, for the examination of physicians desiring certificates, who hold diplomas recognized by the American Institute of Homœopathy.

"(Signed),

H. R. STOUT, M.D., Pres.,

"T. J. WILLIAMSON, M.D.,

"C. W. JOHNSON, M.D., Sec."

which the allopathic school is endeavoring to establish in this country. He generously offers to be one of one hundred to subscribe one hundred dollars ; or one of two hundred to subscribe fifty dollars ; or one of four hundred to subscribe twenty-five dollars to make up the proposed amount.

Dr. Henry, in giving reasons for providing such a fund, issues the following urgent appeal and timely warning :

“Such a fund will enable us to successfully antagonize the form of allopathic *medical censorship* whenever and wherever in any State and territory its influence and power is attempted to be made effective. Unless we do this, allopathic antagonism, *by securing legal control of the right to license homœopathic students*, will surely destroy our beloved system ; and, as a distinct school, the homœopathic will be doomed to the low and uninfluential status that it now holds in all European countries where the allopathic school holds full legal supremacy. The time for windy speech-making and high-sounding resolutions is past. These will prove of little value in this actual contest involving the *life or death* of the homœopathic school of medicine ; for, if we fail in this final struggle for the *right to license our own graduates*, our students will refuse to study medicine under homœopathic auspices, and will shun our medical colleges. We cannot expect our students to attempt to enter upon practice under the legal disabilities now existing in such states as Alabama, North Carolina and Minnesota.”

I will add that such a fund can be made immediately serviceable. The money, as rapidly as collections are paid in, can be wisely and economically applied, partly for procuring suitable counsel, when needed, and mainly in the printing and distribution of suitable articles for publication in the press throughout the country, in order to call public attention to the subject and to awaken public sentiment in support of our bills. Subscriptions forwarded to me, as a member of the Committee on Medical Legislation of the American Institute of Homœopathy, will be promptly acknowledged.

The Committee on Legislation of the New York State Society has obtained subscriptions during the past year of upwards of five hundred dollars to a medical legislation fund, in aid of the work in that State. It is exceedingly important that similar activity and zeal be promptly manifested by the profession throughout the whole country.

Since writing the foregoing I have noticed Dr. Lyon's statements in several homœopathic journals to the effect that the recent decision of the Supreme Court has, temporarily at least, opened the door to

the admission of homœopathic practitioners—a license from an allopathic county board being now unnecessary.

The temporary removal of this barrier may lead to larger accessions of homœopathic physicians, and it is to be hoped it will; at the same time the situation has its drawbacks, and always will so long as the allopathic school is the *only* one recognized by law.

The government will unquestionably recognize the homœopathic physicians in Alabama, as in all other States, as soon as they effect a legal organization. When this has been perfected a homœopathic licensing board can be secured, under which thralldom from allopathic surveillance will be effectually removed. Until this legal status is established all unlicensed physicians must abide the disabilities growing out of illegal practice.

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#### PLANTAGO A REMEDY FOR AURAL SYMPTOMS.

BY HENRY C. HOUGHTON, M.D., NEW YORK CITY.

IN the January, 1890, *HAHNEMANNIAN MONTHLY* we find the report of the Philadelphia County Society's Bureau of Ophthalmology: My eyes were arrested by the sentence which makes my esteemed colleague, Dr. W. H. Bigler, say that he had never had any good results whatever from the use of plantago.

As we had the privilege of calling attention to the uses of this drug, and as I do esteem it a privilege to add another to the list of remedies for diseases of the ear, I must stand sponsor for my god-child and give my reasons for my faith.

In Hale's *New Remedies*, third edition, 1873, my attention was drawn to the summary of characteristic symptoms of this plant because of its similarity to a true otalgia neuralgica, in contrast to otitis media. This is the scope of its action: It has been subjected to too extensive a test, both in the New York Ophthalmic Hospital clinics and in private practice for me to be in doubt. In all cases of otalgia depending on dental irritation we prescribe the 6th dilution internally and use a glycerole of equal parts fluid extract plantago, glycerine and water, applied by dropping it into the meatus or saturating absorbent cotton and plugging the meatus.

We expect as uniform results as we do from *hepar sulph. calc.*, *mercurius* or *pulsatilla* in catarrhal or suppurative otitis media, and

our expectations are realized. So true is this that patients shrinking from the delicate attention of the dentist to whom they are ordered for relief return for "that medicine which relieved the ear." It is sometimes almost impossible to make ignorant patients go to the dentist for the relief of the earache, because they do not understand the reflex nature of the affection.

The neuralgic pains of true otitis are similar to those of otalgia neuralgica, due to direct pressure instead of reflex irritation, hence we expect local application to the tympanum to relieve. Experience has shown us that our hopes are well founded. I will not burden your columns with cases, but assure your readers that the glycerole of *plantago* will afford great relief from the agonizing pains of otitis media. That it will cure otitis media or prove a substitute for the remedies so long used for acute otitis or render paracentesis unnecessary, is not claimed. Nor have I time or disposition to argue the question of depending on internal remedies alone, preferring to leave the disputant to the unanswerable force of an acute otitis media personally or under observation treated by both methods.

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### KALI CARBONICUM.

BY AUG. KORNDORFER, M.D., PHILADELPHIA, PA.

(Read before the Hahnemann Club of Philadelphia.)

PROBABLY no remedy employed by the allopathic school more clearly demonstrates the impotence of that system of medicine than does the potassium carbonate. This salt, though a necessary constituent of almost every tissue of the body, and consequently a most important dynamic agent, has, by allopathic authorities, been relegated to the list of tissue-destroyers, or placed among the important chemical neutralizers of acidity. Its dynamic action being by them entirely ignored, it failed to receive that position in therapeutics to which it was justly entitled.

Hahnemann, perceiving that it must become a potent factor in the treatment of disease, developed, through careful provings upon the healthy, a most excellent pathogenesis of this important drug.

Let me here remark, that in order to secure the best results this salt should be prepared in accordance with the method adopted by

Hahnemann. Failure in this particular has led many physicians to lose confidence in the pathogenesis as found in the *Chronic Diseases*. Hahnemann says, vol. iv., page 1: "Mould about half an ounce of purified cream of tartar, moistened with a few drops of water into a ball, wrap this in paper and let it dry, then placing it in a furnace between glowing charcoals, bring it gradually to a red heat. Take it from the fire, place it upon a porcelain saucer, cover it with a linen cloth, and set it in the cellar that it may attract moisture from the air, which will dissolve out a portion of the kali carbonicum. If it stands for a couple of weeks even the last trace of lime salts will be precipitated. This," Hahnemann says, "will, for all practical purposes, be a sufficiently pure preparation, while in addition it possesses the advantage of being readily duplicated without expensive apparatus." It must be remembered that the "cellar" referred to was one not dried by fire, as are ours to-day. The same result may be accomplished by suspending the saucer in a large covered vessel containing water. Thus much as to its preparation. Let us now briefly study its effects.

The kali carb. patients manifest an irritable state of mind, characterized by being easily vexed or angered; trifles vex them. They also are easily startled, especially when touched; thus, touching the sole of the foot causes the patient to start in affright. In harmony with all this we find that noise is disagreeable. We further observe that anxiety and apprehension hold full sway. This state relates especially to "one's disease." Sadness and weeping form common accompaniments. Aversion to society is often observed, though the opposite may occur.

Let us, however, for the present, depart from the Hahnemannian schematic arrangement of symptoms, it being a plan better suited to ready reference than for systematic study of a remedy.

Kali carb. has won its reputation largely through the beneficial influence which it exerts upon certain forms of disease affecting the respiratory tract, though its action is by no means limited to this narrow sphere. Catarrhal states, such as acute fluent coryza of viscid mucus, accompanied by much sneezing, or sub-acute and chronic forms with induration and swelling of the cervical glands, paleness of the face and frequent nose-bleed, yield to its action in high or low potencies. Obstruction of the nose and ulceration of the nostrils are characteristic. The more chronic forms of coryza have a tough or viscid yellowish-green discharge. In these cases we ought to compare ant. cr., aurum, asafoet., kali bic., nit. ac., lycop., sepia, silic.,



nat. c., merc. sub., merc. viv., mag. m., graph., cinnab., thuja, pulsat., phosph. Post-nasal catarrh also calls for kali carb. In this condition compare cinnab., merc. p. i., osmium, sulph., thuja and nitr. ac.

Pharyngeal catarrh, tenacious mucus, difficult to dislodge, adheres to the posterior wall of the pharynx, especially early in the morning; sensation of a lump in the throat. This may be accompanied by tickling in the throat, causing hawking and coughing. Dryness of the posterior wall of the pharynx is a frequent symptom.

Laryngeal irritation, with hoarseness, is common. Even complete aphonia may occur.

Bronchitis frequently calls for kali carb. The cough is usually spasmodic, even whooping in character, often causing nausea and vomiting, and is usually worse between 3 and 5 A.M. With the cough we may have a pain in the larynx, as if it were raw; also stinging or stitching pains in the throat and stitches in the lower right side of the chest.

Pneumonia, especially when involving the lower lobe of the right lung, and characterized by stitching pains.

Incipient, as well as developed, phthisis, may call for kali carb.; usually, however, as complementary to some other indicated remedy, especially nitr. ac. or silic. We should also bear in mind the fact that in many affections kali carb. follows bryonia with peculiarly good effects. The sputa of kali carb. are either tough, sourish mucus, blood-streaked mucus, or purulent in character.

A peculiar symptom, characteristic of kali carb., and found in cases most varied in character, is a "sac-like swelling between the eyebrow and upper eyelid," usually of both sides. In some cases this swelling spreads, causing a puffed look over and between the eyes.

The asthma of kali carb. is worse in the early morning (3 to 5 A.M.), and better from sitting bent forward, resting the head on a table or similar support; motion and drinking aggravate the dyspnoea.

Endocarditis, with stitches in the region of the heart; also shooting through to the scapula; mitral insufficiency, systolic murmur, and increased second sound resultant upon pulmonary congestion.

The gastro-intestinal mucous tract presents a variety of symptoms at once characteristic and important. Prominent among these we find sour eructations, flatulence, disgust for food, and morning sickness without vomiting.

The nausea is very characteristic. "She feels as if she would faint." This is relieved by lying down. The mental depression in such cases is great. "She feels as if she could lie down and die." In case vomiting occurs, it may be accompanied by this swoon-like failing of strength, or we may have severe stitching pains in the abdomen. Painful vesicles in the mouth frequently accompany the gastric derangements. The tip of the tongue burns as if raw, or as if covered with vesicles.

The abdomen is hard, distended and painful, with shooting and stitching pains therein, and accompanied by pains in the back and down the gluteal region; or stitches in the pit of the stomach and hypochondria, preventing deep breathing.

There is marked torpor of the bowels; an unsuccessful desire for stool, with sensation as if the rectum were too weak to expel it. Very characteristic of the kali constipation is the "anxious and distressed feeling an hour before stool." The stools are hard.

Diarrhoea occasionally calls for kali carb. It is indicated when the stools are light gray and watery, and are accompanied by sharp shooting and stitching pains throughout the abdomen.

We further find hæmorrhoids, which are swollen and bleeding; severe pains in the anus, as from fissure; also stinging, burning and tearing pains, as well as great soreness; violent itching in the anus and scrotum.

Diseases of the female generative organs frequently call for the kali carb. In such cases we often find "a feeling of emptiness in the whole body," or, just the reverse, "the body feels heavy; can scarcely exert herself at all." We also observe absence of mind; the patient seems at a loss to know how to begin to say or do what she wishes; "can't express herself." This may be accompanied by restlessness and thirst.

The menses are too frequent but scanty. Compare alumina, amm. carb., mangan., phosph., silic., strontian. The first menses may be delayed. Compare, also, graph., sulph., pulsat., caust., con., ferr., sepia, nat. mur., petrol., spigel., verat. Suppression of the menses, accompanied by dropsical symptoms, is not uncommon. The menstrual blood has a pungent odor and is acrid, causing an eruption upon the thighs.

Before the menses we find one or more of the following symptoms: Sour eructations, puffiness of the face, pains through the abdomen, increased sexual desire, itching of the vulva, nettle-rash.

During the menses, headache, aching in the small of the back and down the gluteal region.

Leucorrhœa of yellow mucus, with itching burning of the vulva; tearing in the left labium, extending through the abdomen to the chest; pinching pain in the labia; stitches through the vulva; cysts of the vulva, with the characteristic stitches; pinching pains in the vagina during an embrace; the vagina feels sore.

In threatened abortion, the characteristic pains from the back down the gluteal region and thighs afford a reliable guide. The ill consequences of abortion, as well as those following natural labor, such as great weakness, especially of the back, prolonged metrorrhagia, exhaustive sweat and cough, find in kali carb. an oft-indicated *similimum*.

During labor the pains appear insufficient, or are misplaced, running from the back down the buttocks and into the thighs. The latter symptom may occur with the after-pains.

Puerperal convulsions, in which the spasms appear to pass off with frequent eructations, have been promptly relieved by kali carb. Phlegmasia dolens, with the characteristic stitching and shooting pains, has also been cured by this remedy.

Inflammatory affections of the uterus and its appendages yield where the peculiar pains, weakness and mental state of the kali are present.

While thus suitable to many diseases of adult life, kali must not be forgotten in the diseases of childhood and infancy. Especially must it be considered in scarlet fever with swelling of the right parotid gland, high fever and restlessness, which is worse about 3 A.M. The skin is dry, and there is present the sacculated swelling between the eyebrow and upper eyelid. The pains complained of are usually stitching and shooting. Such cases, to the routine prescriber, look like bellad., which, in fact, is often erroneously given. The dry skin, less pungent heat, and the swelling below the eyebrows are sufficient to differentiate the remedies.

Many other disease states may call for the kali carb. Enough, however, has here been given to reach a comprehensive idea of the true genius of the remedy; knowing which, its symptomatology may more easily be mastered and employed in practice.

## DR. BROWN-SEQUARD'S ELIXIR OF LIFE.

BY A. W. BAILY, M.D., ATLANTIC CITY, N. J.

It has been with some surprise that I have noticed the commotion made in the medical world, especially in the "old-school" ranks, by Dr. Brown-Séquard's lately promulgated theory of the "Elixir of Life." Dr. Brown-Séquard is a learned scientist and a noted physician, but he is an old man and his theory is ancient. Hippocrates, Galen and Paracelsus have each sought for elixirs that would make old men young and invigorate the decrepit, and each in turn has thought of spermatic fluid.

There may be a truth in Dr. Brown-Séquard's theory, but the practice is not practicable. First the truth.

Spermatic fluid is continuously secreted by the adult testicle until old age overtakes the man and the function is arrested. Not always with the same degree of rapidity is it secreted. Stimulation of the genitals, either by lascivious thoughts or local irritation, causing a determination of blood to the parts, produces a more active secretion. But the secretion is constant, nevertheless, and in some way must the testicle and spermatic vesicles become relieved of this accumulating vital fluid. But two ways are possible—first by discharge, second by absorption.

The relative quantity of semen absorbed and discharged depends entirely upon the habits of the man, and the effects produced are correspondingly changeable. With the effect of semen discharged, whether during sexual congress, masturbation or nightly pollutions, this paper has nothing to do except as it affects the woman who receives it during intercourse. With these results it has much to do.

It is a notorious fact that a married woman who lives happily with her husband is more healthy, more vigorous, more fresh and beautiful at forty-five than her single sister. Maiden ladies, as a rule, are thin and nervous and irritable. There is a lack about them that is felt not only by themselves, but by their gentleman friends, while a married woman is composed, placid, pleasant, and, as a class, more fleshy. They enjoy better appetites, suffer less from indigestion, sleep better, and yet the great majority of them have gone through the trials of gestation and labor several times. They have double and triple the care and mental anxiety, but their recuperative vigor is greater.

In comparing married and unmarried women, I wish it to be understood that I place in the list of married women only those who have sexual congress with their husbands, and who receive into the vagina the discharged seminal fluid, and not those who are only machines for masturbation, for there is scarcely anything that will undermine a woman's health more surely than the loathsome practice some men have of withdrawing before the discharge takes place. These women, as far as this paper is concerned, are virtually unmarried. Not only in bodily development are married women superior to single, but their mental vigor is greater, their minds are more evenly poised, they are quicker of comprehension, and at forty-five are more pleasant companions.

Again, it is an established fact, that after a happy union of ten, twenty or thirty years, there is a marked resemblance between the husband and wife. She has grown to look like him, not he to look like her, and in many ways will she resemble him in manner. I grant association has much to do with this, but to him who would say *all* this is due to the influence of the stronger over the weaker, and that habit has become second nature, I would answer it has *much* to do with it, but not all. There is a deeper reason. That woman who has never enjoyed sexual congress, who has never retained within her vagina the vital fluid of her husband, is not a healthy woman. She does not develop in either body or mind as her more justly treated sister. She is thin, nervous, irritable, easily discouraged, often melancholic; in fact, in a far more sad plight than when in her maiden state. You can single them out without asking any questions when they come into your office. And *why* this condition? It is not only the gratification that comes with the orgasm that tones up a woman's nervous system, equalizes her circulation, giving refreshing sleep, but there is real strength received by the absorption of seminal fluids, whether impregnation takes place or not. Reason as you may of the mental influence of the man, the stronger, over woman, the weaker; or of the electric influence, the positive man and the negative woman; or of the strength by association and the development called into being by the added duties of wifehood and motherhood; still there is left the unanswered question, why the married woman, at and after the climacteric, is more attractive, more vigorous, more round and full than the unmarried? The only answer that can, in reason, be given, is the absorption of seminal fluid into the blood.

I have stated that in only two ways can the filled testicles and spermatic vesicles become rid of their contents, by discharge or ab-

sorption. Here is one of nature's grand economies. If the result of the absorption of seminal fluid is so great upon the woman, is it contrary to reason to assert that the effect is the same upon the man? His semen is either discharged or else absorbed and turned into the channels that supply him with life and force. But man, in his normal state, generates more than he needs for his own use. This accumulated semen produces in him passion, and he seeks woman that he may impart to her that which an all-wise Creator intended she should receive from him. Man, in his true state, is monogamic. All animals, in their true state, are monogamic; they mate and are true to each other, the male giving to the female his excess of vitality. I use the word monogamic not in its ecclesiastical meaning, but meaning one wife at a time, and living with her alone. The male seeks the female because of the burden of the accumulating semen causing passion; the female receives his attentions because she is conscious of a lack. Hence, the husband supplies to his wife his own vitality, his blood, his nerve force, and she becomes, in truth, part of his own body. Moses says they are one flesh. This is the true reason why she grows more like him, why she is more healthy, more beautiful, more full of life and nerve force than an unmarried woman. The curse of depraved health, resting upon those who pervert the laws of nature in sexual relations, is a just and necessary consequence. A man in health generates enough of this vital fluid for himself and his wife. If excessive sexual congress is indulged in, he loses his portion and nervous phenomena result.

But man reaches old age, his testicles cease to perform their function, and his recuperative vigor rapidly vanishes. A vigorous old man has always left to him, in some degree, his sexual power.

Dr. Brown-Séquard knows all this. He has known it for years; as a young man he knew it. In the prime of life he knew the value of his semen, and now that old age has overtaken him he knows it. When in the vigor of his manhood, and his testicles were active and supplying him with the required amount of vitality, he paid no attention to this matter, but now that old age has overtaken him, and the secretion has become scanty and slow; now that he is feeling the decline of his nerve force and is overtaken by fatigue, he strives to put his knowledge to practical account, and secure from the testicles and spermatic vesicles of the rabbit what his own refuses to give him. He has experimented upon himself, and given his supposed results to the world.

Is Brown-Séquard's theory practicable? Seminal fluid is only of

value while the zoöperm is alive and active. When dead, the fluid is just so much mucus, rich, to be sure, in albumen, phosphates and latent septicæmia. Under the microscope the zoöperm shows great activity for thirty or forty minutes, and I have seen their tails still moving in a feeble way after an hour and a half have passed. Exposed to the air they die quickly. Conveyed as the semen is during intercourse from the body of the male at  $98.6^{\circ}$  to the body of the female at the same temperature, with no exposure to the air, the transplanting is not hurtful, and they may live for several days. But Brown-Séquard's method is death and destruction. He realized the danger of septicæmia, and his process of pounding the genitals in a mortar and sterilizing the extracted fluid is death to the zoöperm, and renders success impossible. The live zoöperm, passing direct from the man to the woman in copulation, is to her life; the dead zoöperm, extracted from the testicles of the sheep and injected into the arm of a man, may mean septicæmia.

But behold the cures, some one cries. What answer will be given to them? I have heard of no cures reported. Our press has been overflowing with the accounts of experiments made upon patients, and everything looks like success if one looks no deeper than the surface. But wait. It has not been long since the old school, and many homœopaths too, were wild over the cures of consumption by gaseous enemata, but it is not now fashionable to kill bacteria in the lungs by blowing the bowels up like a balloon, and the earth opens and takes in as many consumptives as ever. Antipyrine filled the old-school faction with confidence, but heart failure was appended as the cause of death so often that this fashion, too, is becoming old. Changeable as the wind, unstable as the waves, without foundation, the physicians of the old school eagerly grasp, with a desperate energy, any new notion, or old notion in new dress, provided it is a child, legitimate or illegitimate, of one of their own number, only to find it worthless, and throw it away for something equally as useless but newer. I say I have heard of no cures. Time has been too short to produce them. What has been done is the result of imagination, and when the excitement is over these patients will fall back into their old condition, and some, it may be, will be worse. Dr. Brown-Séquard's success with himself is simply auto-impression, and if he lives to see New Year's day of 1890, he will see his theory neglected and his practice abandoned for some newer fashion in old-school therapeutics.

## A CASE WORKED HOMŒOPATHICALLY.

BY ALFRED HEATH, F.L.S., LONDON, ENGLAND.

THE following working may be of interest to your readers, and to some of them it may be useful, as showing in a mathematical kind of way how to find the homœopathic remedy in complicated, or in simple cases, where it is impossible to remember all the remedies. The plan of the working is entirely my own, and I have used it for many years with very considerable success. The first list of medicines should contain all the remedies likely to be mentioned for any symptom of the case in hand; the size of the paper must depend on circumstances; it saves time and the trouble of writing them out if a printed list of medicines, numbering a hundred or a hundred and thirty names, be kept ready to hand, when one can be stuck on the margin of the paper used for working the case. This number will embrace all the most usual remedies; any very unusual ones can be put on another paper. The advantages of my plan may be summed up as follows: It shows at a glance the remedy that covers the totality of symptoms; it also shows what other remedies come next in importance; it is easy to differentiate on the value of the symptoms; it is a map of the case always at hand for reference; and it can be added to, as new symptoms turn up, without losing sight of old ones, and as old symptoms disappear it can be rearranged to show the existing totality; it also shows in a marked degree the truth of the homœopathic law—*Similia similibus curantur*. For instance, I have often, when hearing the symptoms of a case, thought of a certain remedy; I have worked the case, feeling sure that remedy would come to the front, have even tried to bring it there, when some *unthought of outsider* (as in this castoreum case) has taken first place, and I have cured the whole thing immediately with one or two doses. This proves the "Law of Similars" to be a law beyond the shadow of a doubt. The principal book needed is a *good repertory*. I have hitherto found Lippes very reliable, although the case given I worked out with the help of Bell's repertory on diarrhoea.

At the request of Dr. Burnett, of London, the then editor of the *Homœopathic World*, I published some years ago in that journal a case of peritonitis worked out on this plan, in which *veratrum album* covered and cured *every* condition and symptom present in a few hours. Dr. Burnett saw this patient, and was so pleased with the working and result that he wished to publish the plan as it stood. See *Homœopathic World*, February, 1882.



## A CASE WORKED HOMŒOPATHICALLY.

*Symptoms.*—Stool consisting of *green mucus*, with *blood*, *burning at anus after stool*, *cutting pain in the abdomen before stool*, relieved by *bending double*, by *pressure with the hand*, and by *warm application*.

	Bloody Stool.	Green Mucus.	Burning after Stool.	Cutting in abdomen before Stool.	Amel'd by ben'g double.	Amel'd by warm appl'n.	Amel'd by Pressure.	Total.
Acon.	Acon.	Acon.		Acon.				3 Acon.
Aescul.	Aescul.	Aescul.		Aescul.				3 Aescul.
Aethus.	Aethus.	Aethus.		Aethus.				3 Aethus.
Agar.	Agar.	Agar.		Agar.				3 Agar.
Aloe.	Aloe.		Aloe.		Aloe.			3 Aloe.
Alum.	Alum.					Alum.		2 Alum.
Apis.	Apis.	Apis.						2 Apis.
Arg. n.	Arg. n.	Arg. n.						2 Arg. n.
Ars.	Ars.	Ars.	Ars.	Ars.				4 Ars.
Bapt.	Bapt.	Bapt.						2 Bapt.
Bell.	Bell.	Bell.			Bell.			3 Bell.
Bry.	Bry.	Bry.		Bry.	Bry.			4 Bry.
Canth.	Canth.	Canth.	Canth.					3 Canth.
Caps.	Caps.		Caps.	Caps.				3 Caps.
Carb. v.	Carb. v.		Carb. v.	Carb. v.				3 Carb. v.
Castor.	Castor.	Castor.	Castor.	Castor.	Castor.	Castor.	Castor.	7 Castor.
Cham.	Cham.	Cham.				Cham.	Cham.	4 Cham.
China.	China.				China.			2 China.
Cina.	Cina.	Cina.						2 Cina.
Colocy.	Colocy.	Colocy.	Colocy.	Colocy.	Colocy.		Colocy.	6 Colocy.
Cop.	Cop.				Cop.			2 Cop.
Corn. c.		Corn. c.	Corn. c.					2 Corn. c.
Dulc.	Dulc.	Dulc.						2 Dulc.
Elat.	Elat.	Elat.					Elat.	3 Elat.
Gum. g.		Gum. g.	Gum. g.					2 Gum. g.
Hep.	Hep.	Hep.						2 Hep.
Ipec.	Ipec.	Ipec.						2 Ipec.
Iris v.	Iris v.		Iris v.	Iris v.	Iris v.			4 Iris v.
Lach.	Lach.		Lach.		Lach.			3 Lach.
Lauroc.		Lauroc.	Lauroc.	Lauroc.				3 Lauroc.
Mag. c.		Mag. c.	Mag. c.	Mag. c.				3 Mag. c.
Merc. c.	Merc. c.			Merc. c.				2 Merc. c.
Merc. v.	Merc. v.	Merc. v.	Merc. v.	Merc. v.				4 Merc. v.
Nit. ac.	Nit. ac.	Nit. ac.	Nit. ac.	Nit. ac.				4 Nit. ac.
Nux m.	Nux m.			Nux m.		Nux m.		3 Nux m.
Nux v.	Nux v.	Nux v.	Nux v.	Nux v.				4 Nux v.
Petrol.	Petrol.			Petrol.	Petrol.			4 Petrol.
Phos.	Phos.	Phos.	Phos.					3 Phos.
Pod.	Pod.	Pod.			Pod.	Pod.		4 Pod.
Psor.	Psor.	Psor.						2 Psor.
Puls.	Puls.	Puls.		Puls.				3 Puls.
Rheum.		Rheum.			Rheum.			2 Rheum.
Rhus.	Rhus.	Rhus.		Rhus.	Rhus.	Rhus.		5 Rhus.
Sep.	Sep.	Sep.						2 Sepia.
Silic.	Silic.		Silic.					2 Silic.
Staph.	Staph.			Staph.				2 Staph.
Sulph.	Sulph.	Sulph.	Sulph.	Sulph.	Sulph.			5 Sulph.
Tart. e.	Tart. e.	Tart. e.	Tart. e.	Tart. e.				4 Tart. e.
Zinc.	Zinc.		Zinc.					2 Zinc.

## A STUDY OF NEURITIS.

BY WILLIAM A. HAMAN, M.D., READING, PA.

(Being an Abstract of a Paper Read Before the Hahnemannian Society, and Prepared for this Journal by D. C. Kline, M.D., Secretary.)

Two years ago I read an article containing the results of experiments that were suggested by typical neuritis following the hypodermic use of ether in heart failure. In these cases the drug was injected deeply along the nervous trunks; cutaneous anæsthesia, disorders of motility, and even serious trophic lesions resulted. In the experiments sulphuric ether and alcohol were used, and both substances were found to occasion a neuritis running into a necrosis of the nerve trunks at the point of injection. Regeneration commenced on the fortieth day, when pure alcohol was used, and, on the twenty-fifth or thirtieth, when 50 per cent. alcohol was used. The latter is the percentage of alcohol in brandy and whisky.

When the alcohol is diluted to 25 per cent. the necrosis is less manifest, and phenomena of irritation seems to predominate, while the immediate effect of the injection consists rather in a simple diminution of the functional activity of the nerve than in a true paralysis. The resulting neuritis was found to be nearly the same as in disease, one difference being an absence of any migrating tendency in experimental neuritis.

The authors, in making known these results of their experiments, advised caution in the selection of the locality for the hypodermic injection of alcoholic liquors and ether, and suggested that injections of these liquids be made in the immediate vicinity of nerve trunks in lieu of neurotomy, neurectomy and nerve-stretching in those cases requiring such operations.

To homœopathists another thought occurs in connection with the result of these experiments. If the hypodermic injection of alcohol and of ether in the neighborhood of nerve trunks produce typical neuritis, why should not the injection of smaller quantities, in neuritis occasioned by other causes, effect a cure?

This is, in my opinion, crude homœopathy, but it is in accordance with the law of similars; nevertheless, this is so patent as to admit of no dispute. Now, the point that I hope will receive special attention in your criticisms is whether the alcohol or ether could be efficacious if administered by the mouth. I think not, because ether

inhaled or taken by the mouth does not produce neuritis. Neuritis has been observed, however, in a few cases of chronic alcoholism, yet I would be disposed to think that it would be more in accordance with the spirit of our day to use the drug in the same way that it was used when it produced pathogenetic effects in the proving, modifying the quantity of course.

Since entertaining this view, I have had but two cases of intractable chronic neuritis under my care, but, unfortunately, they both left me before I determined to give the alcohol and ether a trial.

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### AN UNUSUAL MANIFESTATION OF URÆMIA.

BY HORACE F. IVINS, M.D., PHILADELPHIA, PA.

(Read before the Philadelphia County Homœopathic Medical Society.)

It is not the object of this paper to claim the discovery of anything truly new, for such may not be the case, but it is proposed to present a statement of a condition which occurred in two persons, during the course of uræmia, the equivalent for which I have been unable to find in the literature searched. The condition is that of paralysis of the muscles moving the left vocal band.

Both patients were over sixty years of age and both had long been troubled with considerable prostatic enlargement. One of these men was referred to me by Dr. D. R. Posey in 1880, at which time I was considerably interested in surgery, being associated with Dr. Charles M. Thomas; the other was one of Dr. Thomas's patients whom I treated during the doctor's absence from the city. In both there was a gradual development of uræmia. At the time of the appearance of the laryngeal paralysis the urine was suddenly nearly suppressed. These conditions occurred before the appearance of the listlessness and the still later coma. In each the paralysis remained to the end, but in neither case was there loss of voice, though there was that peculiar, rolling, uncertain sound during vocalization, such as might be considered almost pathognomonic of this form of paralysis. Articulation was much affected a short time before death. The first case lived about three, the second only two, days after the appearance of the laryngeal paralysis.

No autopsies were made, but the uræmic nature of the cases was evident. The paralysis of the muscles moving the left vocal band seemed undoubted, as the band was stationary in the cadaveric or mid-position; there had been no previous laryngeal inflammation such as would have preceded an ankylosis of the thyro-arytenoid articulation, and the voice was normal in each case, when first seen. In each patient the right vocal band acted well, although a little sluggishly, perhaps. The larynges appeared normal in other respects.

Fagge, in his classical work, says: "In other cases, the principal indication of chronic uræmia is *dyspnœa*. This is said by E. Wagner to be generally paroxysmal, coming on chiefly at night, like asthma. It may also resemble that affection in being mainly expiratory; or, as in a case which occurred at Guy's Hospital in 1865, and in which cedema glottidis was suspected during life, it may be mainly inspiratory, as though there were laryngeal stenosis; or, again, both inspiration and expiration may be free, being simply hurried and deep."

Although one might imagine this description of the case to be referable to a possible paralysis of the larynx, yet, as suggested, the case occurring at Guy's was looked upon as cedematous, and it seems, from Fagge's description, to have been unattended by either a laryngoscopic examination or an autopsy, hence, without a certain diagnosis. The case occurred in 1865, ten years after the laryngoscope had come into general use in Austria, and elsewhere, and only one year before Tuerck gave to the world his famous clinical work on the diseases of the larynx. It seems strange, therefore, that the laryngoscope was not used, as in all probability the diagnosis could have been rendered sure at once.

It is evident that the case referred to by Fagge was not a paralysis, and especially not the form here referred to, since with stenosis the only form of paralysis would be one of both posterior crico-arytenoid muscles only; the voice would, in that case, be quite normal, unless complicated by catarrh, ulceration, syphilis, phthisis, or cedema. In the two cases here reported respiration was not interfered with, but there was an evident vocal defect, as has been stated. Fagge further says: "It may also resemble that affection (asthma) in being mainly expiratory; or, as in the case which occurred at Guy's in 1865, . . . it may be mainly inspiratory."

If "mainly expiratory," an uncomplicated paralysis of the laryngeal muscles could be at once excluded, as expiration is a passive

act, on the part of the larynx, and hence no amount of paralysis could affect it perceptibly. If "mainly inspiratory," uncomplicated paralysis is again excluded, for the same passive function would have caused Fagge to say: inspiratory *only*, instead of "mainly."

In the article on "Uræmia," by Grainger Stewart, in *Quain's Dictionary of Medicine*, we read: "Movements are slow, and speech is somewhat indistinct" in chronic uræmia. "The drowsiness passes into torpor. If the patient is roused to speak, his articulation is thick and indistinct. It soon becomes impossible to elicit any answer; lethargy deepens into coma . . ." Here no reference is made to the condition of the larynx, the speech-defect being due to a disturbance of articulation and not to any disturbance of vocalization. That condition is most probably due to cerebral involvement. This quotation, then, does not throw any light on the cases in question, and as most authors are silent on the existence of any form of vocal defect in uræmia, I can but think that the appearance of paralysis of the vocal bands is an unusual manifestation of uræmia.

It seems to me that the explanation of these cases rests upon the complex and all too little comprehended uræmic changes. It is scarcely possible to attribute them to lesions of the brain, as there was no other paralysis, and at first not even listlessness; they must therefore be looked upon as a result of some involvement of the recurrent nerve; but since neither neoplasm nor aneurism could be detected, the suggestion may be made that they were due to the uræmic poisoning itself, perhaps as a nerve infiltration.

Some may argue that these paralyzes were not the result of the uræmia, but were due to some other condition. To this the answer may be made that, without injury, it is exceedingly rare for this form of paralysis to originate so suddenly. When due to pressure the paralysis usually first assumes the abductor form, the loss of motion affecting the abductors later. In the cases here recorded both sets of muscles were, apparently, involved simultaneously, although there is a possibility that the abductor was involved before the paralysis was noticed, as paralysis of one posterior crico-arytenoid muscle is rarely attended by any dyspnoea unless the patient use considerable exercise, or be subjected to mental excitement. Admitting such a condition, it still appears very remarkable that such a paralysis due to other causes should remain latent, or unrecognized, until the oncoming uræmia appear, and thus be precipitated at the same time that the urine was almost suppressed.

SILICEA BIOCHEMICALLY, PHYSIOLOGICALLY AND CLINICALLY  
CONSIDERED.

BY DR. MOSSA, STUTTGART.

(Translated by S. Lillenthal, M.D., San Francisco, Cal.)

(Continued from p. 41, January number.)

LET us see what silica can do in cutaneous eruptions. The first place belongs to eczema, especially of the scalp, arising more or less from scrofulosis. A woman of thirty-two years, blonde, of sanguine temperament, who formerly suffered from scrofulous ophthalmia, was attacked all over the lips, especially at its corners, by an eruption with large, hard, brown scabs, disfiguring her greatly. Different remedies, including silica 30, failed. She then received silica 4, one drop every third or fourth day. The first few doses of this potency caused considerable aggravation, as vertigo, heaviness of the head, heat, redness of the face, severe pains in the abdomen, nausea, pain in the extremities. After the third dose the aggravation ceased. After the fifth dose the eruption disappeared, but a deep and large ulcer formed on the leg, and it may well be asked whether a milder preparation would not have done equally well.—*Allgemeine Hom. Zeitung*, 24, 153.

A girl of sixteen years suffered from moist tinea capitis on the occiput. *Aquæ sil.*, three times daily, ten drops, cured her in a few weeks.—*Hygea*, 22, 104.

A. Becker cured, with the same preparation, a moist herpes of the hands.

A boy of seven years was treated for two years by old school methods for tinea capitis, discharging a green, foul fluid. Silica 30 aggravated at first; another dose after several weeks. Cured after several months.—*Allgemeine Hom. Zeitung*, 49, 54.

Lepra or elephantiasis arabum is histologically a hypertrophy of the cutaneous or subcutaneous connective-tissue, attacking also the hair, nails and cartilages. Its circumscribed form appears in tuberculous excrescences, having its specific focus in the face and upon the nose. C. Hering, who observed it in the West Indies, says, of silica, that it acted well in nasal ulcers. For the nasal troubles in lepra it is characteristically indicated, when they set in with constipation; closure of the nose. It ameliorated the gnawing pains in the nasal bones, with heaviness when stooping and sensitiveness to pressure.

It acted equally well for the coppery spots, the remnants of the excrescences, or even for the tubers, especially at the nates.

Silicea shows great power over nævi or spots. Lorbacher, *Allgemeine Hom. Zeitung*, 51, 93, publishes this interesting case: A woman of thirty-nine years, suffering from habitual perspiration, washed her feet with cold water, and then danced in tight shoes. Inflammation set in from the toes upwards; the foot-sweat remained suppressed in spite of all treatment. A sensation of disagreeable heat in the affected leg was experienced, while the well one was cold up to the knee. When, after a few years suffering, she came under Lorbacher, he reports: The right leg forms a shapeless mass; the toes can hardly be seen; compressed in ill-shaped forms, similar to elephantiasis. The swelling feels hard all over, cold; the skin covered with white scales and reddish, tuberosus thickenings and dry scabs, as in lupus. The heels and toes looked as if covered by warts. At the edge of the big toe and at the inner malleolus a small, ichorous, painful ulcer, exhaling a fœtid odor like foul foot-sweat, was seen. Severe tearing, fulgurating, lancinating pains in the swelling, especially at night, at atmospheric changes and at the beginning of menstruation, which appears copiously with labor-like pains every three weeks. Sulphur 30, for five weeks, a dose every three or four days, was prescribed without benefit. Arsenicum failed. On account of metrorrhagia, nux vomica, platina, and lachesis were given, but without benefit. Sulphur 6, for several weeks, reduced the pains and the heat. Profuse menses necessitated chamomilla and secale, and then again sulphur. Finally, silicea 12 was tried. After three weeks amelioration began and continued, producing copious purulent discharge, with diminution of the swelling. The degenerated skin desquamated in large pieces, and healthy skin reappeared. With the healing of the ulcers the foot returned to its natural dimensions, and her feet sweated again. There are hardly any traces left of the old degeneration.

*Hygroma Oysticum Patellæ*.—Clotar Müller, *Allgemeine Hom. Zeitung*, 26, 341, cured several cases in a few weeks, with silicea 9, 6, 3. After a few doses peculiar pains appeared in the swelling, especially at night; it softened the tumor which then disappeared.

In relation to *perspiration*, clinical experience has shown that silicea moderates a too copious sweating, especially a partial one, and that it will reproduce it, when suppressed in consequence of catching cold, and this removes all morbid symptoms emanating therefrom. How deeply silicea enters into the biochemic relations of the skin and

of the sweat-glands is shown, as it removes the foul odor of the feet, though no sweating takes place.

*Cephalalgia*.—Silicea is indicated where the galea aponeurotica, the periosteum, and the bones of the cranium are affected. It will be often difficult to diagnosticate whether the dura mater or the arachnoid is the seat of the headache, whether it is the brain-matter or the intra- or extra-cranial connective tissue. Silicea has close affinity for the latter. Schüssler recommends it for headache with simultaneous appearance of small nodules, of the size of peas, on the scalp. Hahnemann, in his introduction to silicea, leads our attention to these nodular eminences on the scalp, and mentions as characteristic symptoms: Vertigo, so that he has to hold on something; headache from the neck to the vertex, preventing sleep at night; daily headache; tearing with heat in the forehead, particularly forenoon; drawing pain in head, as if it would come out through the forehead; pains in head, as if it would burst; pulsating headache; unilateral headache; tearing and pulsating pains in the bones of the face, through the eyes, with sweat on the head in the evening; dulness of head, feels in the evening as if drunk; heat in head; loss of memory; reading and writing aggravate.

Hering mentions throbbing, beating pains with heat and congestion, from exertion, stooping and talking; nocturnal pains from the neck to the vertex, in the forenoon, with tearing, as if everything would be pushed out of the forehead; nodules on scalp; falling out of the hair; great sensitiveness of the skin (of the head).

A young woman of twenty-eight years, brunette, suffered for some time with headache; pain either on vertex, occiput or forehead; at other times hemicrania, with bruised sensation and painfulness to touch, sometimes throbbing, with great weakness of eyes. When the pain is very severe, it awakens her, with nausea and vomiting; less from touch, walking and in the fresh air; it comes at any time, intermits for weeks or appears every two or three days; only for a few hours or continues for weeks; food tastes sticky; has passed pieces of tænia; trembling of extremities and prostration during severe pains. Silicea 30, in diluted alcohol, ten drops daily, was given, from July to September. The first doses aggravated, but a cure followed.—*Allgemeine Hom. Zeitung*, 22, 11.

Dr. Glack mentions another kind of headache suitable to silicea: Headache from organic causes, from overstudy, nervous exhaustion, with vertigo and loss of memory.

Jahr mentions nervous headaches from overstudy; feels a concus-



sion when one steps hard, with tensive pain in forehead and eyes; nocturnal congestive headaches, with throbbing, bursting sensation; heat in the head, especially chronic cases; migraine, with nausea, faintishness and dimness of sight.

Vertigo when sitting, less when lying down; in walking so that she does not know where she is, with fear of falling sideways; with nausea and pyrosis, less when looking upwards; dizziness when getting up in the morning; attacks of dizziness, with tendency to fall forwards; vertigo when sitting (not when walking), especially on carriage riding; loses consciousness for a minute, without obscuration of sight; headache after getting up in the morning, with rotary vertigo sitting or walking, would fall down when stooping; surring in ears, with sensation of falling during motion—feels as though he were drunk; congestion to the right temple; pain in the middle of forehead; a quick, sharp pain, renewed by talking, stooping, or turning round.

A girl of seventeen years suffered from vertigo, less from emotions and stooping, preceded by congestions to head, oppression of the chest and in pit of stomach; headache every forenoon; menses too early, often too long and too copious, followed by leucorrhœa; burning pain in the pit of stomach, radiating to the abdomen, less by walking, sometimes nausea and tendency to diarrhœa. Silicea 30, cured.—*Allgemeine Hom. Zeitung*, 5, 324.

Many symptoms of Meniere's labyrinthine vertigo remind one of silicea. In the right ear a rhythmic bubbling, as if something beats on the tympanum, re-echoing in the head and rendering him anxious; noises like reverberating thunder in ear, with hardness of hearing for four days, especially in the morning when getting up; noises, like ringing of bells, preventing sleep; she has to rise and walk about; vertigo caduca, so that he falls down, but remains conscious.

*Epilepsy*.—Sixteen days after taking the drug. After going to bed and during the first sleep, unconscious tossing about with upper and lower extremities; twitching, with closed eyes and loud snoring; foaming at the mouth; lies there without motion, and when aroused stares about, opens the eyes which do not move, and begins to mumble.

The night and sleep afford indications for silicea. At this time silicea causes congestion to the head; the heart and bloodvessels throb violently; ascending twitchings of the body during a dreamless sleep; sleep is restless, anxious, and full of dreams of a bad nature. One prover, after thirteen days, had a dream, as if he had

an epileptic fit, with a sensation as if something pulled his head sideways.

Hartman says: "Silicea suits epilepsies flourishing on a scrofulo-rachitic soil, or when they arise from the cerebro-spinal system, with these symptoms—after sensation of great coldness in the left side of the body, somnolency with frightened twitching; unconsciousness; he talks nonsense; does not recognize anybody; feels so weak that he cannot turn around, followed by severe convulsions; staring look; twisting of head and extremities; unearthly noises; lachrymation; foam before the mouth; hot sweat and sleep. After several hours, consciousness returns. Nocturnal epilepsy, particularly about the new moon; body stretches out, is then thrown up, but without a scream."

A man of twenty-three years, otherwise robust, had epileptic fits every five or six weeks. Before the attack he always had shaking and turning in the left arm and unconsciousness; after it headache and bilious vomiting. When well, vomiting after cabbage. Sulf., calc., lyc., agar., calc. 30, were prescribed in turn. Fits stayed away for six months. Then every five or six months one dose of calcaria or silicea 30 was given, but still no cure was accomplished. Then silicea 200 was prescribed and caused a decided aggravation for several weeks, especially at night. Since then no attack has occurred.

A woman of twenty years was attacked after confinement with epileptic fits, at first at night, then also in daytime. The aura began "war-like" from the *plexus solaris*, ascended to the brain and ended with the fit. Silicea 3, three drops in 180 grammes of water, a teaspoonful every day, restored her health in three months.

A kind of epilepsy in an apprentice, nocturnal with moaning, snoring, twitching of extremities, foam from mouth, inability to speak, can be awakened by rough shaking, was removed by silicea 30.—*Allgemeine Hom. Zeitung*, 41, 116.

A child of eighteen months had convulsions, which steadily increased for three weeks, so that it had fifteen fits daily, finally paralysis of the right side. Silicea 4, one dose cured, probably helminthiasis the cause, as also in the case of Boëninghausen.

*Paralytic Manifestations.*—A farmer had for a year atrophy of the left hand, with weakness and sensation of numbness in the fingers. Silicea 30, three doses, removed everything.—*Allgemeine Hom. Zeitung*, 8, 235.

We also find under silicea the following symptoms: The arms are as heavy as lead; pain in the shoulder, as from pressure, extend-

ing to the hand, with the sensation as if she could not lift anything, though she has full use of it; paralysis of the forearm; she drops everything; the arm falls asleep at the table or when resting on the arms; paresis and trembling of the right arm from slight exertion; formication in fingers; a stinging pain in one or the other finger, or in the arms, as if they were asleep; in the morning hands and feet feel like dead.

Whether Schüssler's idea of silicea as a connective-tissue remedy explains these symptoms from pathological changes in the cellular covering of muscles and nerves, and the extension between the fibres, is still unknown, but is probable. C. Hering found silicea the remedy in paralysis of the hands of leprous patients. Holcombe reports the case of a negro boy, complaining of pain, swelling, and great sensitiveness in the ball of the thumb. Diagnosing an abscess, hepar and mercurius were prescribed, and poultices applied with benefit; but after a week the fingers, and especially the thumb, began to curve, and after a few days they were stiff in flexion, and every attempt at extension caused excruciating pain. Finally he succeeded and bandaged the extended fingers and forearm firmly on a splint. After six weeks the bandage was removed, but the fingers were still worse in flexion. Nothing was now done for a month, when the atrophic hand could not be used any more. After a few doses of sulphur, silicea acted admirably, and gave to the poor boy the use of his hand again.—*Allgemeine Hom. Zeitung*, 49, 15.

Though chemistry has so far failed to demonstrate silicea in the lens of the eye, clinical experience has demonstrated its usefulness in cataract. An old man with a cataract was treated unsuccessfully with silicea 30, but aqua silicea, three times daily, seven drops, restored some sight in the affected eye.

A carpenter had for years an herpetic eruption on the face. He complains now of a diminution of vision, preventing him from working. Incipient cataract was diagnosed. After spiritus sulphuris, ten drops thrice daily, the eruption reappeared, but vision did not improve. Aqua silicea,\* seven drops daily, brought improvement with moderate sweating on body, but copious on the feet, and calcareous sediment in the urine, and after awhile, a rheumatic inflammation of the foot.—*Hygea*, B. 2, 408. Becker.

A man of twenty years, otherwise healthy, complained of his eyes, which often became inflamed. In these attacks the conjunctiva is red, chemosed, and looks like a piece of raw flesh, with great photophobia,

\* Aqua silicea is a saturated solution of silicea in distilled water, which Becker uses without diluting it any further.

lachrymation, and agglutination of the eyelids; vision nearly lost. Belladonna 30, frequently administered, removed the inflammation in two days; but no improvement in vision, for a thorough examination revealed now a cataract. Silicea 30, at intervals of eight to ten days, restored his sight in three months.—*Arch.*, 19, 1, 77. Argenti.

Massa reports the case of a cabinet-maker, who for a year had a swelling in the left elbow-joint, soft, but now becoming painful and preventing work. Knowing that silicea is recommended for cystic tumors, he received silicea 30, three drops, twice daily. After three days, pain and swelling had diminished, but a ganglion formed on the back of the head of the size of a hazel-nut. Silicea continued, removed the ganglion also, and not a trace of his tumors remained. In the proving of Hahnemann we also read of a ganglion which appeared on the thirteenth day after the drug had been taken. Thus we have learned, thanks to homœopathy, to consider silicea a most valuable antipsoric remedy.

**PROLONGED CASES OF DIPHThERIA AND PERICHONDRIITIS LARYNGEALIS IN CHILDREN.**—Dr. Jacobowitch reports among others the case of a child, one year old, where the diphtheritic process lasted seven weeks, the patient finally dying with the symptoms of apnoea. The autopsy revealed a layer of pus upon the fauces and larynx, and an extensive *perichondritis laryngealis*. A boy of ten years was down with angina diphtheritica, who died with symptoms of suffocation, though through his long disease he showed no symptoms of dyspnoea. The laryngeal cartilage was destroyed in several spots. Another boy, of ten years, had malignant septic diphtheria for fully six weeks before slow convalescence set in, and in a girl, of six years, sixty days passed before she could be considered out of danger.—*Deut. Med. Wochschr.*, 48, 1889.

**LYSSA CURED BY AGAVE AMERICANA.**—A boy, of eight years, was bitten by a rabid dog on February 18th, and remained apparently well up to July 7th, when symptoms of lyssa appeared; he became restless, sleepless, irritable, lost appetite and could only swallow with great difficulty; the pulse was small and frequent; præcordial anguish. On July 17th death was hourly expected, as he had not eaten anything for four days and got furious when food was offered. A piece of agave was now offered which he eagerly grasped, chewed it up and held out his hand for more; he got all he wanted. Thus for three days he chewed and swallowed it with decided amelioration of all symptoms. On the fourth day he swallowed only the juice and spat out the woody parts. He slept the whole night, was fully conscious and asked for food. On July 26th he became tired of his agave, as it tasted bitter and burned his throat. Full recovery ensued.—*Wein. Med. Presse*, 41, 1889.

**DISAPPEARANCE OF AN EXTENSIVE ERUPTION OF XANTHOMA.**—Hardaway, of St. Louis, reports a case of xanthoma which was the most extensive and exaggerated form of the disease that he had ever seen, and which he believes to be without a parallel in literature. In addition to the widespread involvement of all parts of the body with the plane, tubercular and tuberoso lesions of the affection, there existed a most curious zosteriform arrangement of tubercles, or rather papules, in the intercostal region of the right side. In about four years from the time that he came under observation the xanthomatous lesions have undergone complete involution. The peculiar bronzed hue of the skin, which has always been an interesting feature of his case, still persists.—*Journ. of Cut. and Gen.-urin. Dis.*, January, 1890.

## EDITORIAL.

## DR. WILLIAM BUDD TRITES.

DIED on Sunday morning, January 19, 1890, Dr. William Budd Trites. Probably no event in the history of our profession, here in Philadelphia, has created so profound a sensation as the announcement thus briefly chronicled, not only among his fellow-members of the profession, but also in the community in which he was so well known and loved.

He died of heart-failure, at the close of an attack of pneumonia that had followed a neglected influenza. The calls of a large practice, during the prevalence of the late epidemic, caused him to neglect his own case, until sheer exhaustion compelled him to take to his bed in a condition but illy fitted to withstand the onset of the disease that prostrated him. He fell a hero and a martyr to his duty.

Dr. Trites was born in Sunbury, August 22, 1846, and was the eldest son of Dr. David Trites. The family, after residing in Surrey County, Virginia, up to the outbreak of the rebellion, came to Philadelphia, and finally settled in Manayunk. After graduating from the Philadelphia High School, he took up the study of medicine in the Hahnemann College, whence he graduated in 1869, and settled down to practice in Manayunk.

The genial charm of his manner and the unconscious evidences of a moral and upright nature made him exceedingly popular, both as physician and citizen. He was president of the Homœopathic Medical Society of the County of Philadelphia for three consecutive years, and of the Pennsylvania Homœopathic State Society for one year. Besides contributing numerous valuable papers to the several medical societies of which he was a member, we find a number of articles in Arndt's *System of Medicine* from his pen.

For several years he was actively engaged in his Alma Mater as lecturer on venereal diseases, and was quite lately elected temporarily to fill the Chair of Pathology and Practice of Medicine, during the absence of Dr. W. C. Goodno, who was compelled by overwork to take a rest.

From his early youth Dr. Trites was actively connected with the

Mount Zion Methodist Episcopal Church, and identified in various official capacities with its interests. He was one of the originators of the Young Men's Christian Association of Manayunk, and for several years its president.

He was a life-long Democrat,—one against whose honor there was never the breath of a suspicion, and as select councilman, to which office he was elected in 1883, he was conspicuous for his uprightness of character and Christian integrity. He declined a renomination in order to devote himself more entirely to the requirements of a constantly-increasing practice.

Immediately after the Johnstown flood it was owing to Dr. Trites's active exertions that the Twenty-first Ward Johnstown Relief Association was organized with himself as president.

During the last session of the State legislature he was chairman of the delegation sent by the Homœopathic County Society to Harrisburg to secure legislation in the interest of homœopathy, and to his indefatigable labor, and wisely-directed efforts, was due in a great measure the defeat of the unjust Medical Examiners' Bill that had been presented.

Such, the meagre record of a busy, useful life—the inner history of his noble manhood, is unperishably graven in the hearts of all who knew him. The subtle character of the sympathy that went out from him was felt by every one who came in contact with him, and the promise of the first impression never failed. All found in him a reliable friend, and an earnest worker in whatever he had undertaken. To do everything in the best possible manner was the ruling principle of his life, and any recognized mistake was apt to cause him poignant sorrow.

Full of honors, though young in years, but few physicians are privileged to obtain as enviable a reputation as did the subject of this sketch, and in none could the winning evidences of a lovely and noble nature be more conspicuous. Beloved by all who knew him—he is gone, but his works still live. Struck down in the full vigor of his manhood, and with every prospect of a long and prosperous future before him, his untimely end will prove an incalculable loss to his family, to the profession, to his church, and to the community in which he labored so faithfully and so acceptably.

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# GLEANINGS.

## GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

**THE EFFECT OF CHRONIC DISEASE OF THE VALVES OF THE HEART UPON THE SOUND ORIFICES, THE CAVITIES AND THE WALLS.**—Dr. D. J. Hamilton, Prof. of Pathology, University of Aberdeen, in introducing the subject states that the relationship of the condition of the walls and cavities of the heart to that of its apertures altered by disease, is admittedly of the greatest prognostic importance. The object of the paper is to place the pathology of hypertrophy and dilatation upon a firmer footing.

For thirteen years Dr. Hamilton has kept an accurate record of the size of the apertures, the thickness of the walls, the length at the ventricular cavities, the weight of the organ, etc., in nearly every cadaver, passing under his notice as pathologist to the Edinburgh and Aberdeen Royal Infirmaries. The facts derived therefrom serve as the basis of his conclusions. His investigations brought out the somewhat remarkable result, that the only lesions of the valves of the left side which are accompanied by any appreciable distension of the otherwise sound orifices are uncomplicated aortic regurgitance with a wide orifice and uncomplicated dilatation of the mitral. In the former of these, the other three orifices were considerably above the average diameter, and in the latter, both the pulmonary artery and tricuspid were distended, while the aortic remained of natural size. As regards the other classes, it may be noted that where incompetence of a valve was accompanied by constriction of the orifice, the remaining apertures were not sensibly affected. The legitimate conclusion deducible from this is that constriction of an incompetent orifice exerts a salutary influence in preventing distension of the other orifices of the organ. In answer to the questions why does dilatation take place, and what is the increased work performed by the heart, which calls forth the hypertrophy of its fibre, the author cites the two-fold action of the heart, *i.e.*, the action of driving out the contents of the cavities, and of preventing the over-distension of the same. It is thus engaged, not only in propelling the blood, but also in maintaining the tone of the heart-wall. This tonic function of the heart-muscle is often overlooked, but it is one of considerable importance. The cardiac muscle is characterized by rhythmic action being most highly developed, rapidity of contraction well marked and tonicity well marked. The overwork performed by the heart, in aortic regurgitance with a normal sized orifice is chiefly that of keeping up the ventricular tone. If dilatation of the ventricle coexist, increased propulsion efforts may be required. In aortic regurgitation with a wide orifice the only work is to keep up the tone of the ventricle. Where the aortic is incompetent and constricted, the overwork of the heart is two-fold, namely, (1) that of keeping up the tone of the ventricle, and (2) that of driving the blood through a narrow orifice. Where the aortic and mitral are both constricted and are both incompetent, the increased work performed by the left chambers of the heart is in keeping up the arterial pressure. Part of the energy so liberated is expended upon the pulmonary circulation, which, by raising the pressure within the pulmonary vessels, necessitates increased effort on the part of the right ventricle in opening the pulmonary artery valve. This is frequently followed by hypertrophy of the ventricular walls. The unusual energetic contraction also reacts upon the naturally incompetent tricuspid and renders it more incompetent, thus affecting deleteriously the whole venous circulation. In concluding his remarks on hypertrophy from valvular disease, Dr. Hamilton says it must be remembered that the heart, when deprived of its natural locks, may still have a certain inherent power of driving the blood onwards. Just as the œsophagus seizes the draught of liquid, and conducts it to the stomach even against gravity, so the heart may be supposed to do the same with the blood. It is to be borne in mind that an impaired valve is not necessarily

a totally useless valve. It may subserve its purpose in an incomplete manner. The chief redeeming point in valvular disease of the heart, probably, is that the pulmonary semilunes are seldom incompetent. This in a manner separates the venous from the arterial circulation, and prevents the pressure on both sides from becoming equalized.—*The Journal of Anatomy and Physiology*.

**THE CURE OF FACIAL NEURALGIA, ODONTALGIA AND ALLIED NEUROSES.**—Dr. Geo. Leslie, in a paper read before the Medico-Chirurgical Society, of Edinburgh, announces that he has been able to cure many cases of the above-named very troublesome disorders by a very simple procedure. This procedure consists in the application of powdered chloride of sodium—common salt—to the nasal mucous membrane. The salt may be used by the patient as snuff, a pinch of it being taken into the nostrils on the affected side, and in many cases this has been found effectual in preventing a recurrence of the trouble. The best results were obtained when the salt was administered through an insufflator. A small insufflator was used for this purpose, the chamber holding but four grains. As the powder was blown in, the patient was asked to draw air up the nostril. The application produces but little pain or discomfort. Although a single application usually suffices for the immediate inhibition of the neuralgia, especially when it is recent and localized in one branch of the fifth nerve, in other cases where the disease has been of long standing and of extensive distribution, he had found that insufflation repeated every half-minute for about five minutes was required. In conclusion the author reports a series of cases cured by this novel treatment. Among these were cases of odontalgia, cephalalgia frontal and vertical, facial neuralgias of various types, and bronchial asthma.—*Edinburgh Medical Journal*, January, 1890.

**RESORCINUM IN VOMITING.**—Dr. Andeer, of Munich, observed that *chemically pure* resorcin is by far the best remedy in vomiting, especially in affections of the stomach. He tried it in all kinds of vomiting, whether of peripheral or of neutral origin, whether idiopathic or symptomatic, and it never failed to show its beneficent action, even in the obstinate vomiting of hepatic, renal or menstrual colics or in the pernicious vomiting of pregnancy. Lately he also used it successfully in seasickness, and in vomiting after abuse of alcoholic beverages.—*Allgem. Med. Centr. Zeitung*, 97, 1889.

**SPONTANEOUS KELOID.**—Vidal reports the case of a fifty-three-year-old man in whom a keloid, nine centimetres long, three centimetres wide and one centimetre high, developed spontaneously in the sternal region. He did not have syphilis and no discoverable cause could be found. At first it increased in size, but slowly; since 1878, however, it grew more rapidly and became painful. A second keloid has lately developed in the flexure of the right elbow, also without visible cause. Both were treated by multiple scarification. Besnier denies that keloid originates spontaneously.—*Monatsh. für prakt. Dermatol.*, Bd. 9, No. 12, 1889.

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## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

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**CHLOROSIS TREATED BY SMALL VENESECTIONS.**—Dyes was the first to recommend the treatment of chlorosis by small venesections. Wilhelmi has carried out this method in eighteen cases, and has found that in certain cases of anemia, venesection offers better results than any other procedure. The symptoms which indicate it are: More or less sallowness of the face, skin and mucous membranes, headache, palpitations and dyspnea on any exercise, lassitude and inability to accomplish anything, tinnitus aurium, vertigo and tendency to faint, constant coldness of the hands and feet, horripilations and chilliness, difficulty in falling asleep, unrefreshing sleep disturbed by frightful dreams, total insomnia, poor appetite, disgust for milk and eggs, desire for fruit, acids or spiced food, sensation of pressure and nausea after eating, obstinate constipation, falling out of the hair, deficient action of the skin, mental irritability, ill-humor, down-heartedness, œdema of the lower extremities, emaciation, small, weak, readily excitable pulse, and considerable loss in



the quantity of hæmoglobine. The more severe the disease, the smaller the quantity of hæmoglobine; the more severely the functions of the digestive organs are depressed, the more is venesection the remedy. This procedure produces a rapid improvement after the failure of the usual methods. The patient should be in bed when bled; from eighty to one hundred grammes of blood should be abstracted. When menstruation is too copious then the venesection should be performed two or three days before the period. When the flow is scanty, then two or three days afterwards. They should be repeated from every four to eight weeks.—*Allgem. Med. Centr. Zeitung*, 100, 1889.

**INJECTIONS OF DEFIBRINATED BLOOD IN CHLOROSIS.**—Dr. Antiqu, in a paper before the Faculty of Medicine, of Lyons, relates the results obtained by a novel method of treating chlorosis suggested by Teissier. The material employed is the blood of oxen defibrinated. About five ounces of this is injected per rectum twice a day for a week. The treatment is discontinued at the end of that period for a week, and then recommenced. Care should be taken to warm the blood over a water-bath before injecting, and the patient should be directed to retain it as long as possible, any colicky symptoms being overcome by the addition of a few drops of laudanum. According to the author this treatment is more rapidly and certainly successful than any at present resorted to. The proportion of red blood-corpuscles in the blood promptly increases, and mucous surfaces regain their normal color. He attributes the rapid improvement that takes place to the fact that the employment of defibrinated blood fulfils three indications—(1) restitution of the iron; (2) restitution of the oxygen; and (3) restitution of the salts of potash and the chlorides. Dr. Huchards, commenting thereon, mentions that, in a case of his own, he had succeeded in overcoming an anæmia which had resisted all medication.—*Medical and Surgical Reporter*, January 18, 1880.

**HEADACHES AND TINNITUS AURIUM OF PELVIC ORIGIN.**—Dr. Amand Routh, London, after recalling that, in spite of the fact that males have greater brain work, females are much more subject to headaches, in the proportion of sixty-five women to twenty-six men, according to Herman, or of seventy women to twenty men, according to Symonds, the headaches associated with catamenia are almost constantly of the migraine type, but may also be complicated by occipital or vertical headaches if pelvic congestion co-exist. Unlike headache due to cranial disease, their intensity is invariably intermittent. Many authors allude to these headaches, and agree that the catamenial period may provoke them, but that they are to be primarily accounted for by a predisposing heredity. There are, however, headaches just as clearly associated with pelvic disorders as the above catamenial ones. Herman believes that uterine disease may make headaches more severe and more frequent, but hesitates to believe that such headaches are even dependent on uterine causes alone. As regards migraine and other explosive neuroses, Dr. Routh agrees with him. But he also believes that certain pelvic states produce both frontal and occipital headaches without definite predisposing heredity, basing his belief on the fact that as soon as the pelvic state is removed the headaches disappear. The doctor then described five cases in which the chief complaint was headache, and either because pelvic symptoms were associated with it, or because no other organ seemed at fault, the pelvis was examined. The first case was one of migraine, with family predisposition. Exciting cause, endometritis, with stenosis of cervix. Case two was one of frontal headache of some weeks' duration. Cured by dilating the cervix. Case three, insupportable vertical headache, with prolapsus uteri with retroflexion. Hodge pessary, followed by complete relief. He then describes two cases with reflex tinnitus aurium superadded to the pelvic trouble. In both cases the tinnitus was cured by the removal of a mucous polypus. The doctor closes his paper with the following conclusions: 1. So-called *catamenial headaches* are usually of the migraine type, and are due to the general nervous excitation present, similar headaches recurring from other cause. 2. *Migraine* may be also induced by pelvic irritation apart from the catamenia, but there is always a hereditary predisposition, which seems essential to the development of these headaches, which may recur after the removal of the pelvic source of irritation, if other centres of irritation arise. 3. *Frontal headaches*, with no previous tendency to headache, may be induced by cervical stenosis, with retention of uterine contents, such as is common in aged women with senile uterine catarrh, speedy relief following the dilatation of the cervical canal. 4. *Prolapsus uteri, during active sexual life*, may produce *occipital or vertical headaches*, which are worse when the fundus uteri is tilted backward, and in-

cluded between the utero-sacral folds. Flexions or versions, *apart from descent*, do not produce these headaches, not *per se* causing pelvic congestion. 5. *Tinnitus aurium* seems able to be produced by irritation of the cervix uteri, being in the two cases described caused by endo-cervical mucous polypi, upon the removal of which the buzzing ceased.—*The Provincial Med Jour.*, January, 1890.

**CREOLINE IN GYNÆCOLOGY.**—Extensive experiments have been made by Chérar with this substance in 2 and 5 per cent. solutions. The weaker solution has been used for vesical injections in cases of gonorrhœa, five grains being injected directly into the bladder; neither poisoning nor pain resulted; the discharge from the urethra diminished and soon disappeared, injections being made every other day. Gonorrhœal vaginitis was quickly improved by irrigation of the vagina and vulva with a 5 per cent. solution. In purulent cervical endometritis the diseased tissues were first carefully cleansed with absorbent cotton, after which an application of a 5 per cent. solution was made. After a few applications the suppuration ceased. Creoline gauze was found to be an excellent substitute for iodoform gauze in cases of suppuration and hæmorrhagic endometritis, in which a tampon was required. From the foregoing it was concluded that creoline has a very positive effect upon the microbes of gonorrhœa and of pus, and that in ordinary doses it is neither painful nor toxic.—*Annals of Gynæcology*, December, 1889.

**MOIST GANGRENE OF BOTH LEGS FOLLOWING PARTURITION.**—Dr. W. F. Faison reports a case of a German woman, nineteen years old, who, five days after confinement, was seized with a severe and prolonged chill, followed by a temperature of 105° F. Thinking it septic intoxication, he prescribed fluid extract of ergot and sulphate of quinine, and irrigated the vagina and uterus with a solution of bichloride of mercury (1 to 2000). The child was taken from the breast and, in spite of every precaution, an abscess was developed in each breast. Chills continued every few days, with a morning remission and evening exacerbation of temperature ranging from 102° to 105° F. Within ten days she complained of cold feet with an intolerable burning pain, and within fifteen days the characteristic dusky hue of gangrene had made its appearance in both feet, and soon began to slough, exhaling the horrible odor peculiar to moist gangrene.

Although repeated attempts were made to limit the process, it continued, and the patient finally succumbed. Her general symptoms were those of collapse; the pulse was rapid, feeble and finally almost imperceptible at the wrist, the respiration sighing, the breath having a sickly sweetish odor, and the body bathed in profuse, cold perspiration. Just before death, well-marked "typhoid" symptoms were developed. The author thinks it possible this was one of the few important cases reported by Sir James Simpson, in which the arterial obstruction was due, not to embolism, but to local thrombi caused by blood dyscrasia peculiar to the puerperal state.—*North Carolina Med. Journal*, December, 1889.

**MINOR LACERATIONS OF THE CERVIX UTERI.**—Dr. Chas. H. Bushong calls attention to the fact that oftentimes very small lacerations of the cervix uteri give rise to very serious disturbances of health. This fact he thinks is too often overlooked. The symptoms produced by such conditions are tendency to abort readily, leucorrhœa, increased amount of menstrual blood—unless there is anemia, in which case the flow is scanty. The patient often has nervous symptoms, is fretful, and inclined to worry, and frequently loses flesh. An examination will reveal only a small laceration of the cervix. Closer inspection will reveal some cicatricial tissue around the tear, and a uterus slightly larger than normal. Treatment of the cervix in these cases produces most excellent results. The treatment advocated by the author is the application of Monsel's solution to the tear, followed by a tampon saturated with glycerine, to be worn about twelve hours. These applications are made once a week. When the above treatment fails, it is necessary to dissect out the cicatricial tissue, and close the laceration by sutures.—*Medical Record*, January 18, 1890.

**OBSTRUCTION OF LABOR BY AN ENORMOUSLY DISTENDED BLADDER OF A MALE FŒTUS.**—Slecht, interne to Prof. Pawlick, of Prague, reports a case where, owing to prolonged labor, an attempt was made to effect delivery by the forceps. The head of the fœtus was torn off in the operation. The patient was then brought to the hospital, where the accoucheurs found that a large swelling in the form of a huge ball filled the whole uterine cavity. After embryotomy a large quantity of inodorous fluid escaped from the uterine cavity, and labor was soon terminated. An

examination revealed the fact that the fluid came from the enormously dilated bladder of the fetus. The cause of this condition was found to be an obliteration of the urethra. Both ureters were considerably dilated; the rectum opened into the bladder, but no meconium could enter, as the rectum was compressed by the great intra-vesical pressure and the opening was hardly permeable with a probe.—*Wien. Med. Presse*, 46, 1889.

**THE DIAGNOSIS OF PLACENTA PRÆVIA BY PALPATION.**—Spencer (*Transactions of the London Obstetrical Society*) reports in detail seven cases of placenta prævia in which he diagnosticated, by abdominal palpation, the presence of the placenta in, or its absence from, the front wall of the lower uterine segment, the diagnosis being subsequently verified by internal examination. The cases were head presentations in multiparæ, before pains were present and the membranes had ruptured; no anæsthetic was used. In three cases the exact site of the placenta on the front wall of the lower uterine segment was determined; in two cases the placenta was felt when, by vaginal examination, it could not be found. The absence of the placenta from the anterior wall was diagnosticated in four cases.

The patient should lie on her back for these examinations, the bladder having been emptied; the examination should be gentle, made in the absence of pains, prolonged for several minutes, or repeated if needed. When the placenta is in front of the head, it is felt as a spongy mass between the fingers and head. Its edge feels like the segment of a circle within which the touch is obscured; outside, the child is plainly felt. Impulses to the head are not clearly felt through the placenta; impulses to the head through the abdominal walls are distinctly felt where the placenta is absent.—*American Journal of the Medical Sciences*, January, 1890.

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**EYE-SYMPTOMS AS AIDS TO DIAGNOSIS.**—In the December meeting of the New York Academy of Medicine, Dr. D. C. Cocks brought to the notice of the members an outline of the more important facts about the eye and its diseases, a knowledge of which was essential or helpful in diagnosis. *Epiphora* is at times the first symptom of facial paralysis, the orbicularis failing to keep the puncta in contact with the globe. *Inflammation of the lachrymal sac* indicates an obstruction of the nasal duct from neglected nasal catarrh, exostosis or periostitis; when the inflammation persists in spite of treatment, diabetes mellitus may be suspected. *Reddened lid margins* indicate a lowered state of the general system, as well as errors of refraction and muscular insufficiencies. *Ptosis* by itself might mean pressure by syphilitic or rheumatic swellings, a trauma or a nuclear trouble suggestive of general or posterior spinal sclerosis. *Exophthalmos* in Graves' disease gives the diagnosis immediately. *Exophthalmos* of one eye might indicate tumor of the orbit or its neighborhood, periostitis, or even an orbital hæmorrhage in whooping-cough. The correction of insufficiencies of ocular muscles by prisms or tenotomy will often give an entirely new aspect to cases that were formerly obscure. A paralysis of all the external eye muscles indicates a disease not of the eye, but of the central nervous system—the nuclei of the third, fourth and fifth nerves in the floor of the fourth ventricle and aqueduct of Sylvius being implicated. A recurring paralysis of the third, fourth and sixth nerves often gives early indication of spinal sclerosis. Phlyctenular keratitis will indicate reduced health and unsanitary surroundings, and often follows measles, chicken-pox and scarlet fever. Diffuse keratitis shows in a large proportion of cases a syphilitic taint. Keratitis with hypopyon points to infection from some source, possibly nasal catarrh or carious teeth. Episcleritis rarely occurs, except where there is a rheumatic or gouty basis. We will usually find as an accompaniment or cause of iritis either syphilis, malaria, variola, tuberculosis, or rheumatism. The existence of a dilated pupil might clear up a doubtful case of cerebral tumor or syphilitic deposit at the base, or point to a fracture through the apex of the orbit. The writer instances a case of diphtheria which was not recognized until dilatation of the pupil and paralysis of the accommodation occurred.

The ophthalmoscope, Dr. Cocks believes, should be in the hands of every practitioner. A choroiditis of the macula of each eye, with fine specks in the vitreous, is almost pathognomonic of syphilis. A rapidly-forming or soft cataract might be the first symptom in a case of diabetes mellitus. The neuro-retinitis of Bright's disease is of sufficient importance to demand the attention of every physician. Atrophy of the optic nerve may be one of a series of symptoms which prove the previous existence of cerebro-spinal meningitis, basilar inflammation, gumma, alcoholism, fracture of the base, or tumor of the nerve or chiasm. A central scotoma for red is almost pathognomonic of tobacco poisoning. Night-blindness occurs in atrophy of the nerve, anæmia from fasting, and retinitis pigmentosa. Word-blindness shows lesion of the cortex. Acquired color-blindness points to optic nerve atrophy. Limitation of the visual field is found in optic atrophy, glaucoma and retinitis pigmentosa. Monocular hemiopia points to an intraocular lesion, such as detachment of the retina, while binocular hemiopia indicates lesion along the optic tract, or in the occipital lobe of the same side as the loss of vision. Where, in Bright's disease, the patient suddenly goes blind without lesion of the fundus, the cause is probably œdema of the optic centres. Acute glaucoma is sometimes mistaken for a bilious attack, or hemicrania, and chronic glaucoma for incipient cataract. Here the increased tension, dilated immobile pupil, and contracted field would soon settle the diagnosis without even the aid of the ophthalmoscope, were these signs only looked for.—*New York Medical Record*, January 11, 1890.

**THE RELATION BETWEEN PERIPHERAL IRRITATION AND NERVOUS PHENOMENA, WITH SPECIAL REFERENCE TO EYE-STRAIN.**—In an able article on this subject read before the Academy of Medicine, Dr. M. Allen Starr, after glancing at past investigations in this direction, states that it is not his object to throw ridicule on them, but to emphasize the fact which cannot be denied, that, though all forms of peripheral irritation may produce nervous symptoms, no one form has such a special importance as to warrant the extravagant statements made by its earliest supporters. The proposition has been advanced within the past few years that insufficiency of the ocular muscles was a frequent cause of functional nervous diseases, such as epilepsy and chorea. The doctor has been during the past three years constantly testing the ocular muscles as to their power, and he had observed under the same tests, in the same individuals at different times, considerable variation. He also found a relation between the patient's general condition and the power of these muscles. In neurasthenia and other functional diseases, the ocular muscles would, at one time, show a relative weakness, and at another time the test would be negative; but, as these patients recovered under treatment their general strength and tone, a proper strength and balance of these muscles returned. In epilepsy, there was often very evident variation in the equilibrium of the ocular muscles to the tests, before and after an attack. His conclusions, drawn from spontaneous testimony of patients, are that slight ocular insufficiencies do not produce discomfort, and that variations in the muscular power are natural, and that nature warns us of over-exertion in any direction by means of conscious fatigue; hence insufficiency of an ocular muscle, incapable of causing discomfort, is really a matter of little importance. Out of three thousand cases of nervous diseases, the writer can cite only one case of true nervous manifestation undoubtedly caused by eye-strain and, in his opinion, such cases are rare. The conclusion, which the writer believes inevitable, is that, while eye-strain or other peripheral irritation might be a source of nervous manifestation, it is a rare cause of nervous disease. He would class eye-strain with other kinds of peripheral irritation, neither more nor less frequent and important. He does not believe that true epilepsy or chorea could be produced by eye-strain, or cured by its relief, and thinks that the general indiscriminate recommendation of treatment directed to the relief of supposed eye-strain in these diseases will soon come to be recognized as malpractice.—*New York Medical Record*, January 11, 1889.

**CHRONIC NASAL CATARRH.**—In a paper before the New York County Medical Society, Dr. O. B. Douglass, after considering the question, "Is the Cure of Chronic Nasal Catarrh as Difficult as Has Been Supposed," arrives at the following conclusions: 1. The nose is not an unimportant organ, as some would suppose, but, physiologically and pathologically, is of first importance. 2. Its position and function expose it to disease and injury, and its diseases yield to appropriate treatment as certainly as those of any other complicated organ. 3. So-called catarrh is not a

disease *per se*, but a symptom or result of other lesions. 4. Chronic nasal catarrh is usually due to nasal obstruction. 5. Removal of the cause is always the first step toward cure, and this frequently requires surgical interference. 6. The nose and its diseases are deserving of more attention from the general profession, because the consequences of neglect are far-reaching and serious. 7. Chronic nasal catarrh is not as difficult to cure as formerly supposed. In the discussion of the paper Dr. Kitchen, while agreeing with the writer that nasal catarrh was not so difficult to cure as was generally supposed, was firmly of the opinion that the profession in general, and the specialists, had not much to be proud of in this direction. There was no doubt that a certain number of cases could be cured by operative procedures. Therapeutic treatment is not satisfactory, because of the fact that we cannot thereby remove the causes. If the causes are but considered, we must admit that a cure is often out of the question, simply because these causes cannot, under present surroundings, be removed. Chronic nasal catarrh was, in his opinion, a form of malnutrition, as were many other diseases. We were living most unhygienic lives, and it was practically impossible to alter that mode of life in the majority of cases. A change to a correct mode of living, and to a suitable climate, would cure most cases not due to hereditary malformation, traumatism, etc. But how few people could so change their lives! When they continued in their former course the specialist might afford some alleviation of the symptoms, but he could not cure the disease. Dr. Beverly Robinson thought too much stress had been laid upon nasal stenosis and the necessity for surgical interference. Asking the gentleman present to press first upon one side of the nose and then upon the other, breathing through each nostril alternately,—those who could breathe through either side equally well were requested to raise their hands. Very few hands went up; but nearly all raised their hands when asked if they could breathe through one nostril better than through the other. It followed that a certain amount of obstruction or deformity was not incompatible with health. Dr. W. F. Holcombe doubted whether there was a specialist in diseases of the nose present who would undergo the operations upon the nose to which he subjected his patients. He believed that all patients called incurable would get better in a higher, dryer climate. Dr. Messenger said that he, with others, certainly often relieved their patients for a time, but he did not believe at all that they had effected cures. He thought that treating the general system gave most hope when it could be carried out. In the way of local treatment nothing was better in his hands than a solution of salt or soda snuffed up the nose.—*New York Medical Record*, January 4, 1890.

**THE SUBJECTIVE DIAGNOSIS OF ERRORS OF REFRACTION.**—Dr. F. J. B. Cordeiro, in the *New York Medical Journal*, January 4, 1890, offers the following modification of Shreiner's experiment as a simple test of the presence of refractive errors. The patient looks at a twenty-foot distant candle-flame through a small perforation in a diaphragm; in accordance with the fact that images falling on the left of the retina are referred to the right, and, *vice versa*, on moving the perforated disk from left to right, the image on the hypermetropic retina will likewise move from left to right, and the object will appear to the patient to move from right to left, *i.e.*, in a direction opposite to that in which the disk is moved. By similar reasoning it is easily seen that in the myopic eye the object will appear to move in the same direction as the diaphragm. In the metropic eye there will be no apparent motion. Each meridian of the eye can be explored by moving the disk backward and forward in that meridian, and thus the presence of an astigmatism be determined.

**THE USE OF PAPAIN IN EAR DISEASES.**—Dr. McKenzie Johnson says that pain in the ear during the course of a chronic suppuration of the middle ear is an almost certain indication that the secretion is not getting away freely, and that this may be due to the smallness of the perforation, the viscosity of the pus, or to obstruction by growths or by hardened masses of dry pus, debris, or cholesterin. For the purpose of facilitating the cleansing of the ear and dissolving the hardened masses of debris, when syringing is inefficient, he suggests the employment of papain. Fifteen minims of a 5 per cent. solution of the drug are dropped into the ear, care being taken that it reaches the bottom of the meatus. Mindful that bacteria develop rapidly in fluids acted upon by this drug, it should only be allowed to remain for an hour, after which the ear is syringed out with boric-acid solution.

Dr. Johnson has also used papain in cases where a firm plug of wax that could not be removed by ordinary means was found in the auditory canal.—*Edinburgh Medical Journal*, January, 1890.

## GENERAL SURGERY.

CONDUCTED BY

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**SURGERY OF THE KIDNEYS.**—J. K. Thornton, in the Harveian Lectures, gives a review of the renal diseases amenable to surgical treatment, and the operative procedures for their cure or relief.

*Floating kidney* is usually congenital and associated with a lack of perirenal adipose. The organ has a mesonephron, and may be out of reach of a lumbar incision. It is very sensitive, and may become twisted, producing uræmia or hydronephrosis. The condition is best treated by a crescentic pad. Nephrectomy is not justifiable, but nephrorraphy is indicated in troublesome cases. This can usually be performed through the loin, the organ, with its surrounding fat, being fixed to the bottom of the wound by sutures. The areolar tissue should be irritated, and the opening freely drained to produce adhesive inflammation.

*Hydronephrosis* is a distension due most frequently to retention from obstruction in the ureters. The most important symptom is a fluctuating swelling, which may occasionally disappear with increased flow of urine. It is often hard to distinguish this condition from cysts, retroperitoneal, omental or mesenteric, and pyonephrosis. Aspiration may decide the question, and is also a method of treatment. If the fluid re-accumulates after several tapplings, nephrectomy is preferable to nephrotomy and drainage.

*Pyonephrosis* is a similar distension with pus or purulent urine, and is best treated by incision and drainage.

*Renal abscess*, a collection of pus in the substance of the kidney, presents the symptoms of suppuration, renal pain and, perhaps, tumor. Aspiration may be required to decide. The treatment is incision and drainage.

*Perinephric abscess* may follow kidney suppurations on careless aspiration (or disease of the adrenals, ED.). The treatment is obvious. *Calculus* is the commonest cause of the above-mentioned diseases, or may at times result from them. It occurs most commonly in the young and old. The symptoms are lumbar pain, shooting down to the testes or ovaries and the lower extremities, aggravated by jolting; hæmaturia; crystals or bits of calculus in the urine; pyuria; irritability of the vesical neck; reflex digestive symptoms, and at times intestinal colic. It must be borne in mind that the pain may be referred to the unaffected kidney, that such symptoms may present without stone, or that the latter may be lodged low down in the ureter. Calculous suppression of urine may be caused by obstruction on one side only, and quick relief be imperative without positive proof which kidney is affected. The search for a calculus with the needle is to be deprecated as dangerous and uncertain. For these reasons the author advocates his combined method. The abdomen is opened by Langenbuch's incision on the suspected side, and both kidneys and the ureters are palpated. If a stone is felt, it is extracted through a small lumbar incision, the kidney being fixed by the hand in the abdomen. After extraction, the wound is flushed, a drain passed down to, but not into, the kidney, and absorbent dressings applied. If the stone be low down in the ureter, it is reached by an epicystotomy. The advantages of the combined method are that the presence of two kidneys is settled; stone in either organ is not overlooked (in fourteen operations the author failed but once to find stone, and in this case there was subsequently reason to suppose that none was present; on the other hand, Greig Smith gives twenty-five unsuccessful lumbar explorations). Further, the wrong kidney is not unnecessarily wounded; the organ itself is sure to be found, one of the mishaps of the lumbar incision being failure to find the kidney at all; in fat subjects, lumbar nephrotomy may be impracticable; the colon and peritoneum are protected from unperceived injury, by the hand in the abdomen; the kidney and stone are fixed and but a very small lumbar incision is necessitated, which is easily drained, heals rapidly and is not apt to be followed by hernia. The key to the objections is the laparotomy, but, relying on his well-known experience in abdominal surgery, the author considers this almost *nil* in careful and experienced hands.

*Scrofulous kidney* is one in which a primary focus or caseous mass in or near the papillæ breaks down and forms an ulcer; or a number may unite and form a cavity. The symptoms are often obscure: backache, hæmaturia and albuminuria; then a putrid, alkaline urine; later, swelling, pyuria, suppression, uræmia and death.

Tubercle bacilli will settle the diagnosis. To distinguish this from calculus are: the evening temperature rise, hæmorrhage when at rest, more continuous discharge of pus, frequent urination, which is very painful when the bladder is affected. As regards operations the strictest asepsis should be sought for, and even the spray is advocated.

*Puncture* should always be made with the aspirator, never with the grooved needle. It may be of use to distinguish between solid, semi-fluid or fluid enlargements; to relieve distension when, for any reason, nephrotomy is inadmissible; to reduce bulk during a nephrectomy; to attempt a cure in some cases of cystic disease; to discover pus, in which case it is to be followed immediately by incision; to gain time in dangerous cases of calculous suppression of urine.

*Lumbar incision* is indicated in calculous suppression, if experience prove it superior to the "combined operation," for the cure of cysts, abscesses and hydratids, hydronephrosis being still in doubt; for the cure, with drainage, of traumatic pyonephrosis or pyelitis, or early tubercular suppuration; for the possible cure of advanced calculous or tubercular suppurations when nephrectomy is refused; for nephrolithotomy, if proved superior to the "combined method," or if the operation is to be performed by those inexperienced in abdominal surgery.

Of tumors, the most important are the *sarcomata*. In children they are more common and very malignant; in adults they are much less so, appearing in the capsule, invading the adjacent structures slowly, and recurring very late. The latter may be removed; the former should be left alone. Other forms are comparatively rare. Tumors are to be treated by nephrectomy and, especially on account of the small working space, the abdominal method is to be preferred. It is performed as follows: A lateral incision is made outside of the rectus, some four inches in length, and beginning near the costal margin. The condition of the other kidney is first examined, and then the intestines shut off from the field of operation by flat sponges. The outer layer of the meso-colon is incised, the opening enlarged with the fingers and the organ examined. The vessels in the meso-colon, which lie in the inner layer mostly, are thus avoided. In the absence of extensive adhesions the vessels are tied before enucleation; otherwise, they are transfixed, or cut across and tied. The ureter is freed and its open end brought out at the lower angle of the wound. The sac is not to be closed, and drainage can be dispensed with if there is no oozing. In case a lumbar wound has been made, this opening should be drained—*The Lancet*, November 30, December 7 and 21, 1889.

**PERINEAL DRAINAGE FOR SOME FORMS OF CHRONIC SUPPURATIVE KIDNEY DISEASE.**—In the *London Lancet* (December 7, 1889) Reginald Harrison insists on the importance of carrying out the well-recognized surgical principle of free and dependent drainage in the treatment of suppuration in the urinary tract. In cases of stricture the backward pressure of the urine leads not only to dilatation of the ureters and kidneys, but oftentimes to extensive suppuration. In most cases removal of the obstruction is sufficient to bring about improvement, or, at least, prevent further disorganization of the kidney substance. On the other hand there are some in which the process is so far advanced that the suppuration continues in spite of such treatment. If the disease affect but one kidney, lumbar nephrotomy may be resorted to, but as it is usually double, such a measure is out of the question. The continued suppuration is due to insufficient drainage, and to give a continuous and dependent outlet the author proposes perineal puncture and the more or less continuous use of a tube. This prolongs life and adds to the comfort of the patient in any case, and is often curative. When the urine has cleared up and suppuration has ceased the fistula heals of itself, but otherwise it not only persists but resists all attempts at closure. He cites a case of suppurative double pyelitis which he materially benefited by dilating the strictures. The relief was but temporary, and was not complete until the bladder was drained through the perineum, the patient keeping his bed for six weeks. For six months the urine was drawn and the bladder washed through the perineal opening, which was then allowed to heal. The tube used is of soft rubber and held in place by a T-bandage, or of ebonite with movable collar, as recommended by Watson, of Boston. With such tubes the patient can go about. The following points are thought worthy of consideration: (1.) In most cases of suppurating pyelitis caused by obstruction from below, the pus will disappear when the obstruction is removed as in stricture. (2.) Cases in which suppuration persists after such treatment are best treated by a perineal opening which gives free and dependent drainage. (3.) Perineal puncture best meets these requirements and is free from danger.

**TREATMENT OF URINARY FISTULÆ OF THE PERINEUM AND SCROTUM.**—Ebermann gives an interesting *résumé* of the above, and concludes that the first and principal indication is to remove the stricture, which is most frequently the cause of the trouble. If this proves unsuccessful, he recommends that free incisions be made into the callous tissues, converting them into healthy wounds, which, as a rule, heal without any difficulty. In extreme cases he favors epicystotomy, which gives thorough drainage; simple canterization of the fistulous canals will then be sufficient to cause rapid healing. He strongly disapproves of the catheter *à demeure*, as it gives rise to constant irritation of the urethra, and does not prevent the urine from escaping through the fistulæ.—*Internationales Centralblatt für Harn u. Sexual Organe*, 1 Band, 4 Heft, 1889.

**VENEREAL TOXÆMIA**—Under the above title, Lang reports the case of a man, aged twenty-four years, who was unable to retract his prepuce completely, from beneath which there issued a thick purulent discharge. The left ankle was extended, painful, and swollen. The swelling was chiefly in the tissues around the joint, and on the dorsum of the foot there was much œdema. Temperature, 103.4° F. On the day following his coming under treatment the right knee-joint was greatly swollen and distended with synovial effusion. On retracting the prepuce there were seen two phagedenic ulcers behind the corona glandis, eating somewhat deeply into the glands, but no discharge from the urethra or pain on micturition. The case ran a course which may be shortly described as similar to what is called gonorrhœal rheumatism. The urethra was at no time affected, nor was there any history of a former gonorrhœa. This case is reported in order to show that a pyæmic or toxic condition resembling acute or subacute rheumatic arthritis may result from the absorption of morbid products in venereal cases, although the parts affected may be entirely outside of the urethra.—*British Medical Journal*, December 14, 1889.

**GNORRHOËAL ARTHRITIS.**—In the *Annales des Malad. des Org. Genito-urin.*, for August, 1889, is the account of a series of experiments conducted by Guyon and Janet, to demonstrate the presence or absence of gonococci in gonorrhœal arthritis. They could find none by the microscope, and inoculations were without result. They divide gonorrhœal rheumatism into two varieties—(1) a serous and (2) a purulent arthritis. In the former no micro-organisms could be found; in the latter, which is very rare, only the ordinary cocci of pus.

**ACUTE ARTHRITIS OF INFANTS.**—From a study of the acute arthritis of infants, Dr. W. R. Townsend draws the following conclusions: 1. Acute arthritis of infants occurs most frequently during the first year of life. 2. It is pyæmic in character, an osteomyelitis of infant life, and is caused by one of the forms of staphylococci, most frequently the staphylococcus albus or aureus; it may follow traumatism or the exanthemata. 3. The most frequent site of the infection is the epiphysis near the joint, which in early life is frequently intracapsular. 4. The disease progresses rapidly, and nearly 50 per cent. of the cases have terminated fatally, the most frequent cause of death being exhaustion. 5. A more or less complete destruction of the "joint-end" of the bone, pathological dislocations, frail-like joints and loss of length of limb, rarely ankylosis, are the most common results of the disease. 6. The disease is most frequently met with in the hips, the knees and the shoulders. 7. As soon as the disease is recognized, the pus should be evacuated promptly, the joint properly drained, and the parts dressed antiseptically. 8. The treatment of resulting deformities should be conducted on general orthopædic principles.—*American Journal of the Med. Sciences*, January, 1890.

**DIPHTHERITIC ULCERATIONS ON THE PERINEUM.**—W. Hill (London) reports three cases which he observed in the same family, and which he attributes to the use of a water-closet that communicated with poor waste-pipes. The first patient was a ten-year-old boy, who first developed diphtheritic plaques on the perineum, and later diphtheria of the pharynx and larynx, death ensuing. His father had an old eczema of the coccygeal region, at the site of which a painful, gangrenous ulcer, lasting several weeks, appeared. Considerable lymphatic swelling was produced, and two glands suppurated. Six weeks later diphtheritic paralysis supervened. The third case was the eight-year-old sister of the first patient. Diphtheria of the vulva was first noticed, and then the tonsils and bronchial tube became affected. Two days before her death the disease was seen to have invaded the vagina, and had produced a vagino-rectal perforation.—*Monatsh. für prakt. Dermatol.*, Bd. 9, No. 7, 1889.



**TREATMENT OF CHLOROFORM ASPHYXIA.**—A boy aged fifteen years was anesthetized with chloroform preparatory to undergoing an operation for the extirpation of some scrofulous glands on the left side of his neck. As Niedermeyer was loosening the tumors, the assistant discovered that there was no pulse, and a small branch of the carotid artery that had been divided ceased to spurt. Efforts to resuscitate the boy were at once begun. Stroking of the abdomen failed. Severe whipping of the soles of the feet was then tried. After the third vigorous stroke, the patient screamed, pulse and respirations returned, and the hippocratic face disappeared; for five minutes more it was found necessary to continue the whipping until the operation was finished. Neither pain or redness followed this vigorous treatment. M. N. Levo, in this essay on flagellation, recommends the above measure in cases of poisoning by certain alkaloids.—*Wien. Med. Presse*, 45, 1889.

**RESTORATION OF RESPIRATION.**—Asphyxia or apnoea during ether or chloroform narcosis should be treated as follows: (1.) The clothing should be loosened (this should always be done *before* the administration of anesthetics.—Ed.), the mouth carefully cleansed of mucus or any foreign substance. (2.) The neck should be extended, but not bent backward. (3.) The angle of the jaw should be pushed forward and upward to pull the root of the tongue away from the pharynx. (4.) Once the respiratory passage is *known* to be clear, Sylvester's method of artificial respiration should be practiced. The legs should be simultaneously elevated by flexing the thighs to a right angle with the pelvis, or raising the latter as well. (5.) Stimulation may then be necessary, and for this purpose the time-honored whiskey is not advisable, and ether dangerous. The best means is by the intra-venous injection of equal parts of aqua ammonia and pure water. (6.) If this fails, Faradism may be of use but not applied, as is usually recommended, to the phrenic or pneumogastric nerve. The object is not to bring about rhythmical respiration, but to produce painful impressions on the nerves of common sensation and thereby excite deep reflex or sobbing respiration. Local stimulation and heat are also produced. This is accomplished by applying one pole to any part where the nerves of common sensation are plenty, and the other with the wire brush to a neighboring point. In this way the respiratory centres, benumbed by anesthetics or narcotics, are quickly aroused.—*Medical and Surgical Reporter*, January 11, 1890.

**LOCAL ANÆSTHETIC ACTION OF STROPHANTHINE.**—Gley, of Paris, reported to the *Société de Biologie* that when one drops into the eye of a rabbit a few drops of a 1 per cent. solution of strophanthine, a perfect anæsthesia of the cornea with myosis takes place. This anæsthesia lasts for more than three hours. The dose is so small that no other physiological effects are observed from the drug.—*Wien. Med. Presse*, 51, 1889.

**ELECTRICITY IN THE TREATMENT OF INTESTINAL OCCLUSION.**—Herard reports twenty-four cases of intestinal occlusion treated by electricity. The method consists in first administering a salt solution per rectum and then passing a current of electricity. Faradism or galvano-Faradism is indicated in cases of sudden development, galvanism in cases of slower onset. Herard concludes from his experience that electrical treatment in such cases should always be tried before resorting to laparotomy.—*Journal of the American Medical Association*, January 11, 1890.

**TREPHINING FOR GENERAL PARALYSIS OF THE INSANE.**—Paralytic dementia has long been known as a hopeless and invariably fatal disease. It would seem, therefore, that any measure which offered even a remote possibility of altering the morbid process for the better was justifiable. Actuated by such considerations, Dr. T. Claye Shaw had the operation of trephining performed in a case presenting early symptoms of general paralysis. The history of the case shows that the patient had delusions expansive in nature, and he was evidently in an elevated and happy frame of mind, altogether out of proportion to the gravity of his condition. The speech was affected, the tendon reflexes exaggerated, the gait unsteady, and the urine retained. From time to time he had convulsive attacks, and short periods of loss of sensation, chiefly in the left extremities, and his powers of deglutition and talking became more and more impaired, and he seemed to be rapidly becoming demented. On July 28th, he was trephined over the right central gyri, about two inches from the median line. The dura was partly cut away to allow the escape of considerable fluid. Healing was complete on the tenth day. The result of the operation has been improvement in every respect; he swallows more readily, and his utterance

is more distinct. He has had no further epileptoid attacks, and is free from headache. But it is his mental condition that has shown the most marked improvement.—*N. Y. Medical Journal*, January 18, 1890.

**CURATIVE EFFECTS OF ERYSIPELAS ON TUMORS.**—Burns has collected twenty-two cases of tumors which were the seat of idiopathic erysipelas. Three cases of sarcoma were permanently cured. In four cases of lymphoma of the neck, some of the glands entirely disappeared, and the others became smaller. In five cases erysipelas was artificially produced. Three of these cases were of carcinoma of the breast. In one of them the disease was not checked; in another the tumor was diminished to one-half its former size, and the third was practically cured, a small induration in the scar, the size of a pea, remaining. A multiple fibroid sarcoma was diminished in size, and an orbital sarcoma was unchanged.—*Cincinnati Medical Journal*, December, 1889.

**GANGRENE OF THE CHEEK FOLLOWING TYPHOID FEVER.**—Dr. Jos. P. Tunis reports the case of a boy eight years of age, who, in the third week of an attack of typhoid fever, developed a small livid lump on the right cheek opposite the first lower molar. Pressed between the thumb and forefinger it was firm and hard, and gave the patient much pain. The lump enlarged rapidly. Under the application of a warm flaxseed poultice, a gangrenous slough formed. On admission to the hospital, this black slough was still in position, partially separated from the healthy tissues by a ring of granulations. The slough included all the tissues from the epidermis to the mucous membrane, measuring in its longest diameter two and a quarter inches. The partially separated slough was removed with scissors. The periosteum was then found to be affected, and the bone below discolored. The mucous membrane had receded from the blackened bone, leaving five teeth loose in their alveoli. These subsequently fell out. The case made an excellent recovery, under strict antiseptic treatment and nutritious diet. Ashhurst, in commenting on this case, expressed as his opinion that the gangrene was due to localized arterial obstruction, thrombotic or embolic, and not to noma.—*University Medical Journal*, January, 1890.

**TO ABORT A BOIL.**—A writer in the *Wien. Med. Wochenschr.* states that a boil may be aborted by simply scraping the skin over the threatened seat of invasion with a scalpel until a drop or two of blood exudes on pressure.—*College and Clinical Record*, October, 1889.

**SOME PRACTICAL POINTS IN THE TREATMENT OF SYPHILIS.**—In an exhaustive article by Dr. R. W. Taylor on the above subject, he discusses the various methods of treatment, both past and present, and comes to the conclusion that the treatment first introduced by Fournier, and now practiced by the majority of syphilographers, is by far the most successful. It consists in allowing the patient to pass through the primary stage without interference, save cleanliness of the initial lesion, and, as soon as the secondary manifestations appear, to begin a regular course of mercury. This may be introduced into the system in various ways, viz., by the mouth, hypodermically or by inunctions, according to the severity of the disease. In discussing the different methods of treatment, the author's ideas are the same as those of most men who have had experience in treating this disease, that excision of the sclerosis, and expectant treatment as well, are to be relegated to the past. Beginning the treatment in the primary stage is also discouraged. Theoretically it may seem the method, but practically it has proven otherwise, as it leaves the existence of syphilis often times in doubt, delays and modifies the secondary symptoms, and leaves no basis on which to form a prognosis.—*Medical News*, December 7, 1889.

**SYPHILIS FROM UNCLEAN INSTRUMENTS.**—Prof. Lancereaux brought before his clinic a man who exhibited a papulo-pustular eruption over the entire body. The cervico-occipital glands were enlarged, and showed all the signs of a syphilitic adenitis. The cause of the infection was a catheterism of the Eustachian tube. Another case was that of a lady who, a few weeks after some operation on her teeth, had an indurated ulceration of the gums, followed by a diffused eruption and indolent engorgement of the glands, as well as by painful periostitis over the bones of the skull and forearm. In both cases anti-syphilitic treatment restored the patient to health. Dentists, barbers and hair-dressers should also take care to keep their instruments aseptic, as syphilis has been communicated by them, as well as by the physician and surgeon.—*Bull. Med.*, 88, 1889.

# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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**SABADILLA CHARACTERISTICS.**—1. Headache and vertigo, which improve when the eyes are fixed on some special object, or when the patient reflects upon some subject. 2. Gastric disorders, worse early in the morning. 3. Thirstless for water, but has a longing for milk. 4. The vertigo is quite characteristic, in that everything appears to turn around itself.—*Allgem. Hom. Zeit.*, vol. cxix, No. 1.

**ANTIPIRYN IN URTICARIA.**—Miss T., aged twenty-five, has for many years been subject to recurring attacks of hives. Oftentimes, without any appreciable cause, a most extensive crop of urticaria will involve the limbs and abdomen. This often continues without abatement for several days. It has rarely been favorably influenced by drug treatment. After suffering from an aggravated attack, a few hours only, in desperation she took antipyrin in an experimental way. One dose of five grains mitigated the discomfort at once and entirely dissipated the attack. The cure was, in all probability, in accordance with the law of the similars, inasmuch as urticaria has been noted after the exhibition of this drug. Some observers have noted a thick crop of urticaria involving the skin that is not protected by the clothing. Others have discovered swelling of the face and body. A very common condition produced by the drug is "erythema, scarlatina-like redness, with itching and urticaria."—*Current Clinic*, November.

**GRAPHITES IN CHAPPED HANDS, ETC.**—"One drachm of *graphites* to an ounce of vaseline is an excellent application in fissures of the skin, as chapped hands, etc., and many times is homœopathic to the condition."—Dr. Arcularius, *Chironian*, November.

**PULSATILLA IN MAL-POSITIONS.**—Dr. Richard Hughes, in a recent discussion, published in the British *Monthly Homœopathic Review*, speaking of the possibility of *pulsatilla* rectifying mal-positions of the child in utero, said; "It was possible for nature to rectify a mal-position, and, if so, it was possible for us to assist nature with medicines. *Pulsatilla* is useful in labor when the pains are weak from the beginning."

**OBSTETRICAL REMEDIES.**—Dr. Neatby, in a discussion appearing in the December British *Monthly Homœopathic Review*, said *calcareæ* and *silica* were of great value in preventing premature births. *Arnica*, *secale*, *ignatia* and *gelsemium* were very successful in relieving after-pains. *Cocculus* had been useful in the vomiting of pregnancy. *Collinsonia* had given him satisfaction in relieving constipation.

**STIBIUM ARSENICOSUM.**—In the *Allgem. Hom. Zeit.*, vol. cxviii., No. 21, Dr. Mattes says: "I have had several opportunities to use this remedy in very old pleuritic exudations, and it has never disappointed me except in purulent exudations or in previous punctures, and not always then. I consider stibium arsen. a specific for serous or sero-fibrinous exudations, for the left as well as for the right side, with this difference, that it is necessary to give the drug a longer time for the right than for the left-sided affection; fourteen days, at least, for the former, and often five to eight for the latter.

**REMEDIES OF SERVICE IN OBSTETRIC PRACTICE.**—Dr. Goldsbrough, in the December British *Monthly Homœopathic Review*, says he has attended upwards of three hundred labor cases, and he considered that drugs were often of much service, especially in pregnancy. In the vomiting of the latter, *ipecacuanha*, *kresote*, and *apomorphine* were of great value. In heartburn and other forms of dyspepsia *nux vomica* was of service. During the fourth and fifth months a state of spinal irritation and nervous exhaustion was not infrequently met with, and here *sepia* and *actea racemosa* act very satisfactorily. *Collinsonia* 1x was far preferable to aperients in the constipation of the latter months. During labor two medicines had served him well, viz., *ignatia* and *pulsatilla*; the former in exhausted states of the nervous system, and the latter in uterine inertia or fatigue. For this condition, where in former days it was customary to give a drachm of ergot, he now gave five drops of the mother tincture of *pulsatilla*. For after-pains he administered *gelsemium*, two or three drops after each severe pain, and found it of much benefit. If this did not relieve, and the pains were referred mostly to the back and thighs, *actea* was given instead. In febrile conditions following labor, if originating in the uterus, *veratrum viride* tincture was the first medicine he thought of; if in the mammae, *aconite* or *belladonna*, or both. In inflammatory conditions, *aconite*, *mercurius corrosivus*, *colocynth*, *bryonia* or *nux vomica* (in a high dilution) were called for, according to different indications. Injections of hot water with antiseptics were always of service. He believed the internal use of *arsenic* to be homœopathic to septic conditions.

**SOMETHING NEW IN THE VOMITING OF PREGNANCY.**—Dr. Blake, in a discussion on the use of medicines in obstetric cases, said that *tabacum* relieved the vomiting of pregnancy, especially when associated with salivation. The heart-burn of pregnancy was relieved by equal parts of *carbo vegetabilis* and bicarbonate of soda, crude, in teaspoonful doses.—*Monthly Homœopathic Review*, December.

**BROMINE IN PTOSIS.**—In the *Journal of Ophthalmology, Otology and Laryngology* for October, Dr. E. J. Bissell reports an interesting case of ptosis of the right lid in a well developed, light complexioned, young lady. The condition developed gradually "and had been permanent for nearly a year," the palpebral fissure was diminished more than one-half, vision was normal. The chief indications for the use of bromine were "chronic diarrhœa, worse in the morning and after eating the slightest amount of food. Eructations and pain about the umbilicus like a 'thousand needles,' with much flatulence; a number of times a day wind was discharged from the vagina with a loud report." Five days after the bromine was prescribed the diarrhœa was much better and the lid did not droop so much. The remedy was then repeated, in addition to which oxygen was given; in another week she was cured. This patient had been previously under the care of members of both schools of medicine, but without relief.

**KALI MURIATICUM IN DISEASES OF THE EAR.**—In the October number of the *Journal of Ophthalmology, Otology and Laryngology*, Dr. E. H. Linnell presents a paper with this title. The histories of several cases are given in which the drug was used. Some were successfully treated by it, others were not. On this experience he bases some conclusions as to the utility of *kali mur*. He considers its symptomatology closely allied to that of *kali hydr*. in chronic proliferous cases in which the latter drug is superior to the *kali mur*. "The class of cases in which it has been most helpful, and to which it seems to me to be particularly applicable, are the sequelæ of sub-acute catarrh and suppurative cases, in which the disease has been controlled by other remedies, and in which there remains depression of the membrani tympani, with adhesions in tympanum and dried secretions limiting the movement of the ossicles, perhaps with more or less obstruction of the Eustachian tube." He considers *kali hydr*. more servicable in chronic, well-marked, proliferous cases, while *kali mur*. is more helpful in transitional conditions.

**CONFIRMED SYMPTOMS.**—*Benzoic Acid*.—Watery, profuse, offensive diarrhœa when a portion of the stool is whitish-gray and has a sediment like soap-suds; diarrhœa with ulceration of the intestines, after typhus, in drunkards, in rheumatic and syphilitic patients; chronic rheumatism affecting the joints when the urine is brownish-red, as though made of brick-dust mixed with water; it has a neutral reaction and a strong ammoniacal odor.

*Agaricus*.—Chorea which originates from a brain lesion, in which the movements cease during sleep and in the dark. Spasmodic seizures which occur during

the night, or when pressure on the last cervical vertebra causes pain, have their origin in the spinal cord; here *ignat.* or *nux. vom.* is preferable. If the disease has existed a long time, and paralytic symptoms have appeared, *coccul.* should be given.

*Ailantus gland.* cured a case of malignant scarlatina. The patient was comatose; the tip of the nose, ears, hands, feet and legs were icy cold; pulse 140, thready and irregular; eruption had become paler and was a violet color; gangrenous diphtheritic deposit; fetor oris; burning thirst; calor mordax.

*Aloes* cured diarrhœa with rolling in the abdomen and discharge of flatus before stool. Useful in cholera when there is constant rumbling in the abdomen and inefficient urging to stool.

*Ammon. bromat.* was prescribed by G. Eichler at first for croupy cough, then for inflammations of the mucous membrane of the respiratory tract (catarrh in general), with a very scanty mucous expectoration, and for mucous phthisis. He also found it of value in chronic coughs and chronic sore throat of clergymen (also *ammon. iodat.*).

*Senega.*—Great mucous accumulation in the chest, attacks of bronchial catarrh which regularly return during raw weather. *Kali chlorat.* may sometimes take its place.

*Apoc. cannab.*—Dropsy which originates in a renal lesion; although intra-cranial œdema and pleuritic effusions are curable with it. Uterine hæmorrhage, the blood comes away in large clots.

*Argentum nitric.* according to Dr. C. Preston, is preferable to every other remedy when the passage of sand or sediments in general through the urethra produces active symptoms; is superior to *lycopod.* and *nux. vom.*, renal catarrh and attacks of nephritic colic. Little or no pain during urination is an indication for the remedy, although it also relieves when the symptoms seem to call for *canthar.* The pains may be very severe, almost driving one crazy, and extend from the kidneys along the ureters to the bladder; at other times they are burning in character, and are accompanied by the voiding of red sand or uric acid sediments. Its main indication is catarrh of the kidneys. *Argentum* is further useful in chlorosis with metrorrhagia, and in the treatment of uterine hæmorrhages in general; for instance, where they accompany fibroids. Diarrhœa in chlorosis. Symptoms indicating irritation of the spine, cramps, lightning pains which radiate from a centre, hemiparalyses, and, particularly, albuminuria.

*Arnica* prevents the development of carbuncles and the appearance of gangrene.

*Arsenicum.*—In psoriasis it is our best remedy. It markedly relieved a farmer, æt. 50, who was suffering from induration of the lower end of the œsophagus, in consequence of which he had vomiting and collection of food in the œsophagus. He recovered enough to be able to eat again without vomiting the food, gained in strength, and followed his business after receiving four doses of *arsenicum* 3, at intervals of three days.

A woman who had been stung by a bee on a bald spot on the scalp was threatened with suffocation on account of dyspnœa; her body became icy cold, face of a cadaveric color, pulse scarcely to be felt. She received *arsenicum* 12 because *apis*, which usually helped her, had failed to relieve, and because she complained of burning in the chest, abdomen and bloodvessels. Relief was experienced in a few minutes, the hands and feet became warm, and, after the second dose, slight sweating occurred.

*Atropia Sulphate.*—This remedy excelled all others, in the experience of Dr. Windeband, in epilepsy. Its best results are obtained in those cases where marked rush of blood to the head occurs in consequence of paresis of the bloodvessels.

*Nitric Acid.*—Nightly attacks of vertigo, as well as that which appears in the dark. The usually used remedies, such as *bellad.*, *cuprum*, *calcar.*, *caust.*, *silic.*, *hydroc. acid.*, *coccul.*, and *opium*, cure the epileptic vertigo with loss of consciousness; but they do not have the marked nightly attacks of vertigo found under *nitric acid* and *argent. nitric.*

*Aurum.*—Fainting, occurring at the commencement of menstruation, has been cured with *aurum mur. natr.* In angina pectoris *aurum* rivals *arsen.*, even during an attack. Great nervous prostration, with great despondency, as of a heavy weight on the chest, particularly over the sternum.

*Bellad.*—Nervous or nervo-congestive headaches, also those with marked symptoms of ebullition of blood. Constant sensation of heat in the upper portion of the head and in the nape, as if the blood ascended from the nape; occasional painful

beating in the vertex; half-sided facial pain, extending from the upper jaw into the eye, ear, and over the face; only during the day. Violent beating, hammering headache in the forehead and both temples; during the attacks the face becomes red; vertigo; sensation as though the eyes were pressed together. (Atropia sulph. and acon. or aconitin have similar symptoms, and are occasionally required in place of bellad.)

*Calcareæ Aceticæ Soluta*.—Uterine catarrh (leucorrhœa)—is occasionally to be preferred to calcar. carb. Habitual constipation with the leucorrhœa.

*Calendula*.—Cancer and foul, indolent ulcerations; wounds caused by a crushing force and wounds in general; after operations for caries and necrosis. It encourages healthy granulation much better than carbolic acid, etc. Dr. Goullon, *Zeitschr. des Berliner Vereines homœop. Ärzte*, November, 1889.

**PULSATILLA IN LEUCORRHOEA IN A LITTLE GIRL.**—After the failure of a great number of medicines, Dr. E. G. Grahn cured a little girl of an obstinate leucorrhœa with *pulsatilla* 200.—*American Homœopathist*, January.

**MERCURIUS SOLUBILIS IN QUINSY.**—"In quinsy, *mercurius solubilis*, third trituration, a five grain powder, will rarely fail to cure within twenty-four hours, even when the case is on the verge of suppuration. The disease may advance for twelve or twenty hours, but then subsides rapidly."—Dr. Smith in the December *Chironian*.

**NATRUM MURIATICUM IN GLEET.**—Dr. Allen says: "In an old gonorrhœa or gleet, with one last, persistent drop, *natrum muriaticum* is the sovereign remedy, especially with cutting pain after urinating, and when the case has been treated with nitrate of silver."—*Chironian*, December.

**STRAMONTIUM.**—A grand remedy in fright is *stramonium*. It meets the night terrors of children, insanity, chorea, and all troubles arising from sudden, severe impressions upon the nervous system.—Dr. Moffat, in the December *Chironian*.

**IGNATIA IN MUSCULAR CONTRACTIONS AFTER FRACTURE.**—Dr. Moffat says *ignatia* is sometimes useful to control the spasmodic contractions of a limb after fracture.—*Chironian*, December.

**SOME REMEDIES SUGGESTED FOR "INFLUENZA."**—In an article, appearing in the January *British Homœopathic World*, after detailing the prominent symptoms of the prevailing epidemic, suggests the use of the following medicines: *Aconite*, *arnica*, *baptisia*, *belladonna*, *bryonia*, *gelsemium*, *glonoinum*, *natrum muriaticum*, *pulsatilla* and *rhus toxicodendron*.

Languor before fever is found under *arsenicum*, *baptisia*, *natrum muriaticum*.

Headache with fever, *arnica*, *arsenicum*, *belladonna*, *china*, *eupatorium perfoliatum*, *hepar sulphur*, *ignatia*, *natrum muriaticum*, *pulsatilla*, *rhus toxicodendron*, *silica* and *sulphur*.

Foul breath with headache is found under *apis mellifica*.

Foul breath in general is under many remedies, notably, *arnica*, *arsenicum*, *baptisia*, *belladonna*, *bryonia*, *gelsemium*, *hepar sulphur*, *mercurius*, *nitric acid*, *nux vomica*, *petroleum*, *podophyllum*, *rhus toxicodendron*.

*Gelsemium* has headache beginning in the cervical spine, extending over whole head, causing a bursting sensation in forehead and eyeballs.

*Glonoin* has severe frontal headache, affecting the eyes.

*Pulsatilla* has frontal headache with feeling as if the eyes would start out of the head.

The writer gives *arsenicum* the first place as a prophylactic and *natrum muriaticum* the second.

**MAGNESIA PHOSPHORICA** is the remedy for tonsillitis; worse right side; throat is very red and puffy; patient is chilly, tired; head aches and face is flushed.—*California Homœopath*, January.

**SCUTELLARIA** is well spoken of in evils arising from excessive cigarette-smoking, weak heart-action, etc.—*California Homœopath*, January.

**NATRUM SALICYLICUM IN TINNITUS AURIUM.**—Dr. John H. Clarke, in the December *British Homœopathic World*, reports two cures of ear difficulty, associated with noises in the right ear, with *natrum salicylicum* 3d.

**RUMEX IN BRONCHITIS.**—Mrs. S., aged fifty years, had, from slight exposures, been contracting a succession of colds, culminating in a severe acute bronchitis. The cough was violent, paroxysmal and painful. It was teasing, persistent, aggravated by cool air, excitement, or by anything which increased the volume or rapidity of the inspired air. The sputum was frothy, tenacious and slightly flecked with blood. *Rumex* 2x dilution, in water, every hour, gave prompt relief and effected a complete cure.—*Medical Current*, December.

**CALCAREA CARBONICA IN DIARRHŒA.**—In the December *Medical Current* are reported two cases of obstinate diarrhœas occurring in children cured with the carbonate of lime in the third potency. The well-known calcarea symptoms were present.

**PHOSPHORUS IN SENILE DEAFNESS.**—Phosphorus, in a weak, oleaginous solution, is claimed by Sapolini to diminish the opacity of the drum of the ear, increasing the circulation and improving the hearing in the deafness of old age. Successfully employed in sixty-two cases.—*New York Medical Times*, January.

**A KEYNOTE OF STAPHYSAGRIA.**—Dr. Clarke says: "In cases of throat affection, such as enlarged tonsils, if the patient complains of *stitches flying to the ear* (especially the left) *on swallowing*, staphysagria is the remedy."—*Homœopathic World*, January.

**SILICA IN CATARACT.**—Dr. Ussher, in the January *British Homœopathic World*, reports the cure of a cataract, occurring in a female of twenty, with silica 6th and, 30th. The doctor thinks the most good was accomplished by the 30th.

**ARGENTUM NITRICUM IN THE BRAIN-FAG OF BUSINESS MEN.**—Dr. G. H. Burford reports that in a business man of forty-five, who was melancholic, suicidal, and who lost all interest in his business, after the failure of sulphur, thuja and psorinum, he ultimately prescribed argentum nitricum, first in the 6th, afterwards in the 30th, and still later in the 200th, and cured the case in marvellously quick time. The following were the indicating symptoms: Hypochondriasis, lethargy and drowsiness during the day; headaches, worse when warm and after food; great flatulence after meals, relieved by belching; "no real appetite for food;" constipation alternating with diarrhœa, and certain nervous symptoms.—*Homœopathic World*, January.

**REMEDIES FOR NERVOUS DYSPEPSIA.**—Dr. Samuel Lilienthal, in the *North American Journal of Homœopathy*, for December, has an article on "Nervous Dyspepsia." He gives the following symptoms of nervous dyspepsia, and then the remedies: Eructations, mostly without smell or taste, exceptionally acid; sensation of pressure and tension in the gastric region; distension of the stomach by flatus, so that the patient cannot bear anything tight about the waist; hyperæsthesia of the nerves of the stomach, > from alcohol or food; globus rising upward; sensation of stone or heavy load in the stomach; præcordial anguish at one spot or radiating; dyspnœa and palpitation from upward pressure of the diaphragm; pain in the stomach, < from acids and fats; gastric pains radiating downward and backward; pains from light food, while heavy food is at other times easily digested; vomiting of all food off and on; emaciation and marasmus; inappetency or bulimia; diarrhœa or constipation; insomnia or somnolency.

*Eructations Relieve.*—Argentum nitricum, baryta, dioscorea, cocculus, graphites, kali carbonicum, lachesis, lycopodium, natrum muriaticum, nux vomica, oleum animale, phosphorus, senega, ratanhia, sepia, tartar emetic. *Without taste.*—Aconite, agaricus, aloes, ammonium carbonicum, argentum nitricum, asarum, arnica, arsenic, baryta, belladonna, bryonia, caladium, carbo vegetabilis, causticum, chelidonium, china, colchicum, cocculus, conium, cyclamen, iodine, ipecacuanha, iris, kali bromatum, kali bichromicum, lachesis, lac caninum, magnesia phosphorica, magnesia sulphurica, sulphur, mezereum, natrum muriaticum, oleander, oxalic acid, phosphorus, platina, ranunculus scleratus, rhus, sabina, sulphur, tabacum, tartar emetic, veratridm album. *Acid eructations.*—Acetic acid, aloes, ambra, ammonium carbonicum, asarum, baryta, belladonna, bryonia, carbo vegetabilis, causticum, dioscorea, gelsemium, iodine, kali carbonicum, magnesia carbonica, natrum muriaticum, nitric acid, nux vomica, petroleum, phosphorus, phosphoric acid, sepia, silica, sinapis albus, sulphur, sulphuric acid, tabacum, zincum.

*Sensation of Pressure and Tension in Gastric Region.*—Arsenic, belladonna, calcaria, cocculus, conium, helleborus, ipecacuanha, lycopodium, nux moschata, nux vomica, opium, ratanhia, sabina.

*Fulness, Oppressed Breathing.*—Natrium sulphuricum, nux moschata, prunus.

*Tension.*—Aconite, asafoetida, bryonia, carbo vegetabilis, clematis, chamomilla, croton tiglium, kali carbonicum, magnesia muriatica, nux vomica, ranunculus scleratus, stannum, staphisagria, tartar emetic.

*Sensitiveness of Stomach.*—Ammonium carbonicum, aranea, arsenicum, baryta, carbo vegetabilis, causticum, cocculus, colchicum, croton, hepar, lachesis, lycopodium, magnesia carbonica, natrium muriaticum, nux vomica, oleum animale, sulphuric acid, sulphur, terebinthina, veratrum album.

*Sensation of a Stone in the Stomach.*—Agaricus, baryta, bromium, bryonia, chamomilla, cocculus, gentian, natrium muriaticum, nux vomica, opium, sepia, silica, sulphuric acid.

*Præcordial Anguish.*—Arsenic, causticum, chamomilla, cicuta, cocculus, coffea, cuprum, gniacum, jatropa, laurocerasus, nux vomica, plumbum, secale, stramonium, veratrum album.

< *from Acids.*—Aloes, antimonium crudum, arsenic, belladonna, ferrum, ipecacuanha, lachesis, natrium muriaticum, nux vomica, phosphoric acid, phosphorus, sepia, staphisagria, sulphur.

< *from Fat Food.*—Arsenic, asafoetida, carbo vegetabilis, colchicum, ipecacuanha, magnesia muriatica, natrium muriaticum, nitric acid, pulsatilla, sepia, sulphur, tartar emetic, thuja.

*Stomach Pains > after Eating.*—Fagopyrum, lycopodium, nux vomica, petroleum.

**PARIS QUADRIFOLIA.**—Great dryness of the tongue when waking from sleep, at any time; coated white, with roughness and without thirst, and with bitter or diminished taste. Patients suffering from spinal irritation frequently have sensation of expansion of the brain. They often say the head feels "as large as a bushel measure;" fulness in the temples, ears, root of the nose, throat and eyes. The eyeballs feel expanded, as though the lids would not cover them. Heaviness, like a weight, in the dorsal and cervical regions, and numbness in the fingers, with lame, heavy, paralytic pains in the hands and feet. Such patients sleep with the mouth open, and the tongue and fauces are always dry on waking, and there is no thirst. *Paris quadrifolia* has relieved many cases having these symptoms.—*California Homœopath, September.*

**POPULUS.**—Catarrh of the bladder; urine contains large quantities of mucus and pus; tenesmus, especially of old people; inflammation of the bladder; urethritis; micturition painful, scalding, especially during pregnancy. Valuable for tenesmus of bladder following laparotomy or ovariectomy.—*California Homœopath, September.*

**OCIMUM** has been found useful in renal colic. Uric acid diathesis, with large deposits of red sand, particularly if the patient is subject to a pain in uterus.—*California Homœopath, September.*

**CUBEBA.**—Nasal catarrh, with fetid odor and catarrh of the throat; mucus trickles from the nose into throat, with soreness and hoarseness; obstinate otorrhœa; offensive discharges; chronic inflammation of the bladder, with cutting and constriction during micturition; hæmorrhage from bladder; necessity to urinate every ten or fifteen minutes; prostatitis.—*California Homœopath, September.*

**MAGNOLIA.**—Pains of various kinds in different parts, worse in joints, constantly changing places; muscular and articular rheumatism; rheumatic pains in clavicles, in back, etc.; shooting in all limbs. In cardiac affections, with faintness in stomach, vertigo, debility, nausea as from tobacco, fear, frequent breathing, palpitation, suffocation, numbness, etc., pain in heart, constriction of throat, aortic aneurism crampy pain in heart, dry cough, vertigo and angina pectoris.—*California Homœopath, September.*

**WYETHIA.**—Chronic pharyngitis; dryness, with constant desire to clear the throat; tendency to atrophy of the mucous membrane; pharynx dark red, sensitive, soreness of the muscles of the palate, following severe influenza. Granular sore throat,



with burning and enlarged follicles; frequent inclination to clear the throat; throat feels swollen; epiglottis dry and burning; constant desire to swallow to relieve the dryness, yet no relief; swallowing difficult.—*California Homœopath*, September.

**MELILOTUS** is an important remedy for certain neurasthenic conditions; patient wakes before 3 A.M., is melancholic, has insane delusions, thinks it is too expensive to eat, is suspicious of friends, fears losses, ruin, etc.; religious melancholia; congestive headaches.—*California Homœopath*, September.

**PECULIAR SYMPTOMS.**—According to Dr. Berridge, *cinnabar* has a feeling of shortening of left leg in walking.

*Causticum* has a feeling of shortening of right leg on rising.

*Carbo animalis* has a feeling of elongation of right leg at night on lying down.

*Thuja* has a feeling of elongation of left leg.—*Homœopathic Physician*, September.

**PHOSPHORIC ACID IN DIARRHŒA, WITH PROLAPSUS ANI.**—Dr. Clarence N. Payne prescribed podophyllum 3 for a ten-months' old baby, who had from three to ten movements per day. The movements were thin, watery, profuse, painless, in color almost like water; very offensive; some excoriation; no flatulence. Podophyllum helped the prolapsus slightly, but the after symptoms were not better. The child had not lost weight for the number of stools. *Phosphoric acid* 200 was given, but did not act so well as the 3d.—*Homœopathic Physician*, September.

**SOME NEW REMEDIES FOR POST-NARAL CATARRH.**—In the September *Medical Advance*, Dr. H. D. Champlin gives the following remedies:

*Fagopyrum* is the remedy where every exposure increases the catarrh, dry crusts are formed, and there is intolerable itching and granular appearance of the posterior nares.

*Penothum Sedoides*.—Posterior nares raw, as if denuded; continual feeling as though the posterior nares were moist.

*Sulphuric Acid*.—When discharge trickling down from nares is a lemon-yellow color, and of thin consistence.

*Teucrium*.—Large, irregular clinkers are hawked up from posterior nares.

**SOME REMEDIES FOR CRAMPS IN THE CALVES OF THE LEGS.**—In cramps in the calves of the legs, if *cuprum* fails to bring about beneficial results, think of *strontiana carbonica* 3x, especially when associated with cold feet. *Secale cornutum* 2x, when complicated with uterine difficulties. *Ammonium muriaticum* 1x, in pregnant women.—Dr. H. D. Champlin, *Medical Era*, September.

**REMEDIES SUITABLE FOR THE DISORDERS OF MALE AND FEMALE SEXUAL ORGANS.**—Dr. Samuel Lilienthal translates an article by Dr. Francis Villar, on "A Comparison Between the Affections of the Genital Organs of Males and Females," and makes comment and therapeutic additions, which we briefly summarize:

*Aurum*.—Testes mere pendant shreds, and female sterility; chronic induration of testicles from mercurio-syphilis and ovarian affection, or induration of uterus, from same cause; bruised sensation in genital organs of both sexes; suicidal tendency.

*Apis*.—Hydrocele, with or without cyst; in dropsy of scrotum; in neuralgia of testicle it is as valuable as in ovarian neuralgia, ovarian dropsy or tumors; stinging pains.

*Arsenicum*.—Chimney-sweep's cancer; phagadenic chancre; cancer of the mamma or uterus; ovarian dropsy; hydrocele; burning pain; restlessness, mental and corporeal.

*Colocynth*.—Ovarialgia and ovarian tumors; probably useful in irritable testicle; painful spermatic cord.

*Graphites*.—In both sexes impotence and sterility, though the desire for an embrace may show itself off and on; swollen testes and enlarged ovaries; constitution below par; malignant tumors.

*Hamamelis*.—Swollen, hard testicle, sore to the touch; varicocele; pains run down the spermatic cord into the testes; again severe neuralgic pains darting from

testes up to stomach, causing nausea and faintness; vaginismus; ovarian soreness and tenderness; chronic sub-involution; chronic congestion of the ovaries.

*Barium*.—Senile atrophy; sexual desire; mental and bodily atrophy; premature morbid senility.

*Iodum*.—Atrophy of the sexual organs; glandular hyperplasia; hydrocele; ovarian dropsy; hypertrophy of the testes; ovarian cysts.

*Lac Caninum*.—Ovaralgia.

*Ophidians*.—"Perhaps they give us, in their primary action, great excitement of sexual desire, only to be followed, secondarily, by impotence. The same violent desires, even nymphomania, we meet in *lachesis*, less so in *crotalus* or *elaps*; ovaralgia belongs to all, but in *crotalus* we meet, primarily, a depraved state of the blood, while in *lachesis*, paresis of the vaso-motors precedes the blood-deterioration." Climacteric period.

*Lilium Tigrinum*.—Males—Cardiac neuralgia; constrictive pain in the heart, extending through to scapulae; increased sexual desire; lascivious dreams. Females—Great sexual desire; burning, stinging, cutting, grasping in ovaries, ovary swollen nearly to size of child's head; pelvic organs feel swollen, aching around, not in, the uterus; voluptuous itching in vagina, with feeling of fullness in parts.

*Lycopodium*.—Sexual desire markedly diminished in males; in women, nymphomania; mental and bodily exhaustion; the old man's balm; nymphomania is not genuine—is a mere momentary excitation from the pressure of wind or water on the sexual organs; tubal dropsies; ovarian tumors; stagnation and varicosity; old women, lean and of feeble muscular development.

*Mercurials*.—Epididymitis; shooting pain in testes and spermatic cord; salpingo-ovariitis, pain extending toward the hip; no relief from sweat. The *iodides of mercury* have some reputation in sarcocele and other tumors of the testicles; ovarian tumors and cysts.

*Nux Moschata*.—Mental and bodily atony; the male is inclined to an embrace, but the genitals are relaxed; in women, great irritability of the pelvic viscera, worse during irregular menses, when ovaries and uterus are swollen and sensitive to pressure.

*Nux Vomica*.—Ardent people; easily excited desire, power weak; given to debauches and high livers; orchitis, with stinging and spasmodic contractions extending into the cords, the testes being hard and retracted; ardent brunettes, suffering from crampy, stitching pain deep in pelvis, and their menses are not only too early and profuse, but the intervals are too short, showing a nearly uninterrupted congestive state in those internal sexual parts, which may often cause constipation.

*Phosphorus*.—After masturbation, both sexes; neurasthenic; alarmed at the state of their health; impotence and sterility in consequence of excessive voluptuousness; in males, the nervous system most shaken; in women, a chronic congestive state of the sexual organs, if not relieved by profuse and long-lasting menses, with pains in the small of the back and palpitations; ovaritis, metritis, displacements; gonorrhœa in women, discharge mucus or milky, with stitches through the whole length of the vagina, and great aversion to sexual intercourse; in the male, orchitis and hydrocele in consequence of gonorrhœa.

*Platina*.—Ill-effects of pre-pubic masturbation; itching, tingling at the anus; haughtiness.

*Pulsatilla*.—Sweet temper; muco-purulent discharges; suppressed discharge from urethra, orchitis following; enlarged or indurated testicle; enlarged prostate; hydrocele; venous congestion.

*Septa*.—Portal stasis; venous congestion; in males, sexual erethism, neurasthenia and dyspepsia; in women, an enlarged, heavy uterus, indurated os; displacements; peritonitis, following gonorrhœa.

*Staphisagria*.—Neurasthenia; atrophy of the testicles after onanism; ovarian symptoms after masturbation or imperfect coitus; mental irritability.—*North American Journal of Homœopathy*, August.

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## BONE-SUTURING IN COMPOUND FRACTURES.

BY DE WITT G. WILCOX, M.D., BUFFALO, N. Y.

(Read before the Homoeopathic Medical Society of the State of New York, February 11, 1890.)

THE old adage "There is nothing new under the sun" is well exemplified in some of the recent surgical procedures; way back in the shadowy days of medical lore some mind bolder than its fellows seems to have thought of, if not carried out, our later day surgical triumphs. Let us see what our professional forefathers had to say about compound fractures. Hippocrates speaks on this subject thus: When the bones protrude through the flesh, particularly the long bones, they may best be reduced by the use of a lever made of iron; pass the lever between the two ends of the bones, and by using one end of the fragment as the fulcrum, and the other fragment as the weight, the bones may thus be put in place. If this cannot be done, he advises the fragments sawed off sufficiently short to make possible their reduction. If the fracture has existed two or three days before being seen, he says no attempt should be made at reduction for fear of convulsions. In such cases he advises allowing the bones to slough, as far as they protrude, and then let the flesh heal over them. In all cases, he adds, compound fractures are very dangerous. First, because of the danger of convulsions; second, because of the danger of bilious fever, and third, because of that fatal condition—mortification. I do not find in any of his works, however, any mention of bone-suturing.

In the text-books on surgery, written before the days of antiseptics, the teaching is not made so materially different as we might expect.

As recently as 1879 the per cent. of mortality in compound fractures of the forearm in Guy's Hospital was 17 ; of the leg, 28 per cent. ; of the thigh, 36.5 per cent, or one in three. This great mortality has been due greatly to the lack of cleanliness or antiseptics, and to the failure of the bones to unite, owing to the difficulty of securing immobility. It is not my purpose to go into details of the treatment of compound fractures further than it relates to the subject in hand, that of bone-suturing. The first account I find on record of uniting bones with any form of suture is that of Deaffinbach. For ununited fractures he drilled holes in ends of the bones and inserted ivory pegs ; these were allowed to remain for as long as four months, and indeed it was found afterwards they were quite harmless after a presence of two or three years. In 1805, Horeua tied the obliquely-divided bones together, where there had been delayed union, with metal wire carried around them. In 1838, Dr. Rogers, of New York, advanced upon the method by passing the wire through holes drilled in the fragments so as to keep them in apposition. Dr. Bigelow, of Boston, reports a cure of ten out of eleven cases of ununited fracture by suturing with wire passed half through the thickness of the bone. Although the cases of ununited fracture or delayed union are somewhat rare, yet the cure of these few cases is oftentimes a troublesome question. After trying the milder measures, such as toning up the patient's health, securing as perfect immobility of the affected limb as possible, and rubbing together the fragments, if this is still unsuccessful recourse may be had to the method of suturing. This is best done by cutting down directly upon the bone, stripping up the periosteum, sawing off the fractured ends just sufficiently to freshen them, and drilling obliquely through each fragment so that when the suture is introduced it enters at the surface of the bone, a few lines from the extremity, and emerges near the centre of the exposed end, close to the medullary canal. It is then re-introduced in the reverse manner into the other fragment and emerges upon the surface. The wire is then made secure by tightly twisting, and if it be a large bone two or three sutures may be required. By exercising care as regards sepsis there need be no great danger in the proceeding. Drainage is best employed and the external surface sewed up closely. As to the kind of suture used, it varies with a strain put upon it and the preference of the operator. As already stated, the older surgeons used ivory pegs, and these are still used with success ; but steel wire is now more frequently employed.

M. Schede, of Hamburg, recently exhibited to the Congress of German Societies of Surgery, some gilt steel needles  $3\frac{1}{2}$  centimetres long by 1 millimetre thickness, used with advantage by him in cases of pseudoarthrosis. Ten or twelve of the needles are inserted into the soft part of the bone and an antiseptic dressing applied. The needles are kept in place about fifteen days. He adds that so far this simple and convenient procedure has succeeded in all cases in which it has been used. Whale tendon, kangaroo tendon, and bunches of horse-hair have also been employed.

Let us now consider the treatment of compound fractures where bone-suturing may be used to advantage. If the fracture be in the leg or forearm, where there are two bones, and both fractured, the difficulty of keeping them in apposition is greater than where there is but one bone. I would not advocate that all cases of compound fracture require suturing, but such as present, first, considerable laceration of the soft parts, second, where the ends of the bones are markedly serrated, and third, where the fracture is comminuted as well as compound. These conditions all call for a firmer fixation of the ends of the bone than can be obtained by any kind of an outside splint; for the reason that if the soft parts be greatly torn there will necessarily be much swelling, which in itself prevents the accurate and firm adjustment of any form of a splint during the first few days. Hence there must be some movement of the fragments at the period when immobility is most essential; every movement of the fragment adds to the irritation of the soft parts and only prolongs the swelling, and augments the danger of gangrene. I said the bones should be sutured if the ends are badly splintered. To attempt to replace such a fragment that protrudes from the soft parts, is to run the risk of lacerating them, as well as rupturing the bloodvessels. In those cases saw off the splintered ends and suture. The fact that there is still too great a mortality from these cases, the fact that we yet too frequently are obliged to amputate because of gangrene, and the fact that not infrequently we find ununited fractures following these compound injuries, are sufficient arguments to induce the surgeon to keep well in his mind the resource of suturing the ends of the bones. In resection, especially of the knee-joint, suturing is a much more common proceeding; indeed few surgeons would resect a knee-joint without fastening the bones together in some secure manner. Wyeth was the first to introduce steel drills and nails; these he drove through the tuberosity of the tibia into the femur, one on either side. Another method was to drive steel nails at right angles

into each side of the femur, about two inches above the point where it had been resected; the tibia was treated in like manner; a stout wire was then passed around these nails in the form of a figure eight, one on either side; these nails were allowed to remain from three to four weeks. Considerable success has followed the use of the suture in comminuted fractures of the skull, and in the replacement of the button of bone removed by the trephine. Now that the surgeon is called upon more frequently to operate about the skull any advance in securing in place and in showing the growth of the piece of bone is of great importance.

A number of proceedings like the above have of late been reported with excellent results. The instrument used in drilling the holes are of various patterns; an ordinary gimlet will answer in the absence of more surgical-appearing instruments. Hamilton's drills are perhaps more frequently used, although I have had difficulty on different occasions in making them work in a compact tissue of bones. The ideal instrument for this work is the electro-osteotrite described by Dr. Roberts, of New York, which consists of a drill propelled by an electric current passing over wires, which connect the drill with a small motor.

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### THE ALBUMINURIAS OF PREGNANCY—THIRD PAPER.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

#### DIAGNOSIS—(*Continued*).

THE urine for twenty-four hours being collected and measured, the day urine compared in quantity with the night, attention should next be paid to its *quality*. The quality of urine depends on the solids dissolved in it. Urine of good quality is urine in which the solids are in normal ratio to the water. For example, urine in quantity 1450 c.c. in twenty-four hours, if containing 58 grammes of solids, is of *good* quality as regards total solids. Urine in quantity 2000 c.c., if containing but 36 grammes of solids, is of *poor* quality as regards total solids. Urine may be of fair quality as regards total solids, but of poor quality as regards urea, and *vice versa*. The distinctions will be found to be of help in the diagnosis of acute nephritis or congestion from chronic nephritis, and also in the dif-

ferential diagnosis of the various forms of chronic nephritis. I have devised a method of marking the quality of urines just as I would mark the quality of examination papers on a scale of 100. According to the most recent analyses—those of Yvon and Berlioz—the averages are as follows:

	Adult Male.	Adult Female.
Quantity of urine in twenty-four hours, .	1360 c.c.	1100 c.c.
Sp. gravity, . . . . .	1.0225	1.0215
Urea in 1000 parts, . . . . .	21.5	19
Total urea in twenty-four hours, . . . . .	26.5	20.5
Phosphoric acid in 1000 parts, . . . . .	2.5	2.4
Total phos. acid in twenty-four hours, . . . . .	3.2	2.6

The quantity of urine voided by any patient in twenty-four hours may be readily compared with the normal by reference to the following table. The figures to the left, under "Male Patients," denote the total quantity of urine in twenty-four hours, while those to the right indicate the comparison with the normal standard marked on a scale of 100.

TABLE III.  
WATER—DESCENDING SCALE.

MALE PATIENTS.		FEMALE PATIENTS.	
Quantity of urine in 24 hours.	What per cent. com- pared with normal average.	Quantity of urine in 24 hours.	What per cent. com- pared with normal average.
1360	100	1100	100
1290	95	1045	95
1225	90	990	90
1155	85	935	85
1090	80	880	80
1020	75	825	75
950	70	770	70
885	65	715	65
815	60	660	60
750	55	605	55
680	50	550	50
610	45	495	45
545	40	440	40
475	35	385	35
410	30	330	30
340	25	275	25
270	20	220	20
205	15	165	15
135	10	110	10
70	5	55	5
35	2½	25	2½
Suppression.	0	0	0

Example: Suppose a male patient voids on an average 960 c.c. of urine in twenty-four hours, what is the mark on a scale of 100? Answer: 70 per cent. +. Suppose a female patient voids 400 c.c.? Answer: 35 per cent. +.

N. B.—The scale is arranged in multiples of the figure *five*. Results are given in terms of the *nearest* multiple of five; for example, 45 per cent. of 1360 is (accurately) 612, but in the scale this product is given as 610, which is that multiple of five *nearest* 612.

TABLE IV.  
RELATIVE AMOUNT OF UREA—DESCENDING SCALE.

MALE PATIENTS.		FEMALE PATIENTS.	
Parts of urea in 1000 of water.	What per cent. of normal average.	Parts of urea in 1000 of water.	What per cent. of normal average.
21.50	100	19.00	100
20.42	95	18.05	95
19.35	90	17.10	90
18.28	85	16.15	85
17.20	80	15.20	80
16.12	75	14.25	75
15.05	70	13.30	70
13.98	65	12.35	65
12.90	60	11.40	60
11.83	55	10.45	55
10.75	50	9.50	50
9.68	45	8.55	45
8.60	40	7.60	40
7.52	35	6.65	35
6.45	30	5.70	30
5.38	25	4.75	25
4.30	20	3.80	20
3.23	15	2.85	15
2.15	10	1.90	10
1.08	5	0.95	5
0.54	2½	0.48	2½
0.00	0	0.00	0

For clinical purposes the approximate numbers may be used, and in most cases the quantity of urea may be marked 100, 90, 80, etc., neglecting the intermediate percentages. For example, urine of twenty-four hours of a male patient, containing 8 grammes of urea, may be marked 30 as regards quantity of urine. Urine of a female patient, containing a like amount of urea may be marked 40, and so on.



TABLE V.  
TOTAL UREA IN 24 HOURS—DESCENDING SCALE.

MALE PATIENTS.			FEMALE PATIENTS.		
Total urea in 24 hours, in grammes.	Approximately.	What per cent. of normal average	Total urea in 24 hours, in grammes.	Approximately.	What per cent. of normal average
26.50	27	100	20.50	21	100
25.18	25	95	19.48	19	95
23.85	24	90	18.45	18	90
22.53	23	85	17.43	17	85
21.20	21	80	16.40	16	80
19.88	20	75	15.38	15	75
18.55	19	70	14.35	14	70
17.23	17	65	13.33	13	65
15.90	16	60	12.30	12	60
14.58	15	55	11.28	11	55
13.25	13	50	10.25	10	50
11.93	12	45	9.23	9	45
10.60	11	40	8.20	8	40
9.28	9	35	7.18	7	35
7.95	8	30	6.15	6	30
6.63	7	25	5.13	5	25
5.30	5	20	4.10	4	20
3.98	4	15	3.08	3	15
2.65	3	10	2.05	2	10
1.32	1	5	1.03	1	5
0.66	$\frac{1}{2}$	$2\frac{1}{2}$	0.53	$\frac{1}{2}$	$2\frac{1}{2}$
0.00	0	0	0.00	0	0

TABLE VI.  
RELATIVE QUANTITY OF PHOSPHORIC ACID—DESCENDING SCALE.

MALE PATIENTS.		FEMALE PATIENTS.	
Phosphoric acid in grammes, per liter of urine.	What per cent. of normal average.	Phosphoric acid in grammes, per liter of urine.	What per cent. of normal average.
2.50	100	2.40	100
2.38	95	2.28	95
2.25	90	2.16	90
2.13	85	2.04	85
2.00	80	1.92	80
1.88	75	1.80	75
1.75	70	1.68	70
1.63	65	1.56	65
1.50	60	1.44	60
1.38	55	1.32	55
1.25	50	1.20	50
1.13	45	1.08	45
1.00	40	0.96	40
0.88	35	0.84	35
0.75	30	0.72	30
0.63	25	0.60	25
0.50	20	0.48	20
0.38	15	0.36	15
0.25	10	0.24	10
0.13	5	0.12	5
0.07	$2\frac{1}{2}$	0.06	$2\frac{1}{2}$
0.00	0	0.00	0

TABLE VII.  
TOTAL PHOSPHORIC ACID IN 24 HOURS—DESCENDING SCALE.

MALE PATIENTS.		FEMALE PATIENTS.	
Total phosphoric acid in 24 hours, in grammes.	What per cent. of normal average.	Total phosphoric acid in 24 hours, in grammes.	What per cent. of normal average.
3.20	100	2.60	100
3.04	95	2.47	95
2.88	90	2.34	90
2.72	85	2.21	85
2.56	80	2.08	80
2.40	75	1.95	75
2.24	70	1.82	70
2.08	65	1.69	65
1.92	60	1.56	60
1.76	55	1.43	55
1.60	50	1.30	50
1.44	45	1.17	45
1.28	40	1.04	40
1.12	35	0.91	35
0.96	30	0.78	30
0.80	25	0.65	25
0.64	20	0.52	20
0.48	15	0.39	15
0.32	10	0.26	10
0.16	5	0.13	5
0.08	2½	0.07	2½
0.00	0	0.00	0

It will be noticed that Tables III.—VII. are all on a *descending* scale. On the other hand, a patient may void *more* urine than normal, or there may be more urea than normal. For such cases I have devised a system of marking on an *ascending* scale, viz., 100, 105, 110, 115, etc., in this case, taking Parkes's averages as a standard, viz.: quantity of urine, 1500 c.c., urea, 33.2 grammes, phosphoric acid, 3.2 grammes—all in twenty-four hours.

Any figure *between* the averages of Yvon-Berlioz on the one hand and those of Parkes on the other, may be regarded as approximately normal and be represented by the figure 100. Different observers have reported different mean figures, according to nationality, but by taking the Yvon-Berlioz figures as a standard for the descending scale and Parkes's for the ascending, we leave a very considerable margin for variations, which may be entirely within the normal range of our own patients.

Lastly, I divide urines into four classes, A, B, C, and D, not only as regards quantity in twenty-four hours, but also as regards urea, phosphoric acid, etc. Class A includes markings averaging from 75

to 100 as to quantity, or as to urea, etc. Class B includes markings from 50 to 75. Class C, 25 to 50. Class D, zero to 25.

A few examples will illustrate the use of my method in representing by figures the deviations of any urine from the normal standards :

CASE 1.—FEMALE PATIENT.

*Usual Method.*

- (1.) Quantity of urine in twenty-four hours, 900 c.c.
- (2.) Urea, grammes per litre, 15.
- (3.) Urea, total in twenty-four hours, 13.5.
- (4.) Phosphoric acid, grammes per litre, 1.1.
- (5.) Phosphoric acid, total, 1.

*New Method.*—Normal = 100.

- (1) 80, (2) 80, (3) 65, (4) 45, (5) 40; or
- (1) A, (2) A, (3) B, (4) C, (5) C.

It is seen at once by inspection of the figures or letters in the new method that the urine is especially deficient in phosphoric acid, both relatively and absolutely, and trouble of further computation or comparison with normal is saved. It will be found convenient to adopt a regular order in marking or classifying, representing quantity of urine by (1), relative urea by (2), total urea by (3), relative phosphoric acid by (4), total phosphoric acid by (5). The *figures* in the new method represent more closely the deviations from normal than the *letters* A, B, C, etc. But for most clinical purposes the letters are sufficient. In general terms, then, the urine in Case 1 is somewhat deficient in total urea, and especially so in relative amount of phosphoric acid and in total phosphoric acid. In other respects deviations from normal are not marked, the deficiency in water and in urea, grammes per litre, being about the same.

[I am publishing a pamphlet in which are given a number of tables, both in American and French measures, and adapted to all classes of cases.]

By this or any system which the physician chooses, the character of the urine from time to time should be noted; the points of especial importance being those numbered (1), (2), (3), (4) and (5).

## THE APPLICATION OF SKIN-GRAFTING.

BY M. J. BUCK, M.D., BALTIMORE, MD.

THE introduction of skin-grafting to the profession by M. Revardin, in 1870, and the subsequent researches by Mr. Pollock, marked an era in the advancement of conservative surgery. Many conditions that had hitherto been irremediable were by it made amenable to treatment.

It is my purpose in this brief paper to describe the plan of conducting skin-grafting that I have usually followed. While this plan does not differ essentially from that laid down in the books, yet, in some of its minor details, it presents advantages that have led me to present this communication. The first step in the operation should be a thorough cleansing of the surface of the wound with water that has been boiled and permitted to cool sufficiently to allow of its use without producing acute pain. Then, in case the granulations are exuberant, they should be clipped off with scissors curved on the flat, or, and I prefer this latter method, they should be treated by the application of nitrate of silver in stick, by gently but quickly passing it over the parts. Next, clean lint, anointed with cosmoline or olive oil should be applied. In forty-eight hours this dressing should be removed. All pus and shreds of tissue should be removed with antiseptic absorbent cotton and sterilized water. The patient is now ready for the application of the grafts. A small piece of skin is clipped from one of the folds of the skin, preferably from that at the bend of the elbow, where this tissue is the thinnest and the most free from hair. The portion removed is next placed upon a smooth surface with its epithelial surface up. I prefer to place it upon the nail of my left thumb, to which it very readily adheres. I then cut it into as small pieces as possible with a delicate knife. To apply these small grafts to the ulcerating surface, I first puncture the latter with a tenotome, and allow a drop or so of blood to flow from the wound thus made; then I press the graft as deeply into the puncture as I can with the flat surface of the blade of the tenotome. It is held *in situ* for a moment or so in order to prevent the blood from washing the fragment of skin away. Following this method, the adhesion of the graft is furthered, and its rapid growth insured.

The three cardinal points in the practice of skin-grafting are: 1. The securing of a clean healthy surface, free from exuberant granu-

lations; this surface should be exposed to the air for not less than one hour that it may become glazed. 2. The individual grafts should be made as small as possible, and should be applied quickly after being liberated from the flap of skin of which it formed a part. 3. The surface of the ulcer should be punctured with a narrow sharp-pointed knife, and the graft pressed well into the punctures.

The operation having been completed, perforated oiled silk should be placed over the wound, and over this mercurialized lint, and again over the lint, antiseptic absorbent cotton. The whole should be retained by a rather tightly-applied roller bandage. The dressing should be renewed not oftener than once in three or four days, and the surface cleansed with antiseptic cotton.

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#### DISSEMINATED SCLEROSIS, WITH CASE.

BY W. M. BUTLER, M.D., BROOKLYN, N. Y.

(Read before the Homœopathic Medical Society of the County of Kings, December 10, 1889.)

I HAVE selected as the text for the present article the following case which came under my care in the Brooklyn Homœopathic Hospital, the details of which I have drawn from the records of that institution made by Dr. W. H. Sawyer.

O. A., Norwegian, æt. 22; builder, brought to the Brooklyn Homœopathic Hospital by ambulance on June 25, 1888, suffering from heat exhaustion. On admission he presented the following symptoms: complete unconsciousness, stertorous breathing, contracted pupils, very rapid pulse, and temperature in the axilla, 108° F. He was immediately put into a cold pack, which reduced the temperature to 101° in about two hours. Injections of brandy and glonoin hypodermically were administered. At 3 A.M. the following day, his temperature had again reached 104° F. by a gradual rise of .4° each hour. Again the cold pack was applied, and again it brought the temperature down to 100° F. Glonoin 3 was now prescribed. Patient was still unable to swallow. His pulse remained almost imperceptible; at times he required stimulation by hypodermic injections of brandy. Beef-tea and milk were administered by rectal enemas. He regained consciousness on June 27th, about 8 A.M. He could now swallow and take brandy and milk by the mouth. Glonoin was continued. On June 28th, he complained of a sore throat and some pain in his head. His pupils were dilated, and he became very nervous; temperature, 100°; R. Bell. On June 29th, he had occasional clonic convulsions, followed by starting up and trying to get out of bed. His head was very hot and his pupils still dilated. His mind was not rational at all times. The throat seemed very sore so that he could not swallow. Enemas of beef-tea and whisky

every three hours, and belladonna internally were ordered. July 1st brought no marked change, except that the head was not as hot as before, and he was able to swallow occasionally. R. Hell. July 2d, vital signs normal; consciousness regained. During the succeeding two weeks he gradually developed marked symptoms of disseminated sclerosis. By July 14th he had slight control over any of his muscles. Intentional tremor is well marked so that the patient can with great difficulty carry a cup to his mouth, and often spills the contents in his attempts; pronounced nystagmus and scanning speech; patellar reflexes exaggerated. On July 25th he could not stand or sit without support. When he reached out to take anything his hand came up with a jerk. He had very imperfect control over muscles of upper or lower extremities. During the remainder of his stay in the hospital he varied somewhat as to his symptoms, at times apparently better, then worse again. The characteristic symptoms remaining unchanged, on November 15th he was by our advice removed by his friends and sent back to Norway.

The point of especial interest in this case is its ætiology, the undoubted cause of the disease being the patient's exposure to intense solar heat, as no symptom pointing to disseminated sclerosis had appeared prior to this exposure. Among the causes mentioned by different writers on this subject we find no reference to sunstroke as a direct or indirect agency in its production. The causes to which it has been credited by the authors at our command are heredity, prolonged exposure to damp cold, excessive mental and bodily exertion, intense emotions, traumatic influences, as injury of the head, concussion of the entire body, and railroad injuries, pregnancy, hysteria, syphilis, or as a sequel of acute diseases like typhus, cholera, or variola. The direct relation of cause and effect in the case just cited warrants us in adding sunstroke to the list of agencies responsible for this most dread disease.

Owing to the comparative infrequency of this disease, it may not be unprofitable for us to briefly consider some of its most important characteristics.

Disseminated, multiple insular sclerosis, or *sclerose en plaques disséminées*, as it has been variously designated by different authors, is a chronic inflammation of the brain and cord.

The characteristic anatomical lesions consist of hardened foci, varying in size from microscopic dots to granules as large as a hazelnut. Often clearly discernible by the naked eye, often of a hard cartilaginous consistency, they may be scattered irregularly through any part of the brain or cord. Although liable to be found in any part of the gray or white matter of these organs, the nodules seem to

show the greatest predilection for the anterior columns of the cord, the various parts of the cortex cerebri, the medulla oblongata, the floor of the fourth ventricle, the pons, corpus callosum and pedunculi cerebri. The great dissimilarity of distribution of these nodules in different cases explains the protean character of the symptomatology of the disease. Diverse as the functions of the several parts of the brain and cord may be its symptoms. Any description, therefore, of its symptomatology must be general and subject to multiple modifications in individual cases. No disease more emphatically emphasizes the importance of the revelations of that little army of quiet workers, who, by their experiments on the lower animals have revealed the peculiar functions of the different parts of the brain and spinal cord. Only by the light of this knowledge could one understand how one and the same disease could present such varied manifestations.

To mention all the symptoms which have been observed in different cases of this disease would be but to evert the normal functions of the several portions of the brain and cord. We can simply notice the most common and prominent symptoms, ever bearing in mind the numerous additions and modifications which the disease is liable to present.

The onset is usually slow and first signs indefinite and uncharacteristic. The patient complains of being tired and weak and walks unsteadily and with difficulty. Ankle clonus and tremor of the foot on extension may be found, which, with symptoms on the part of the cranial nerves, suggests the true nature of the disease. A marked belt sensation and other forms of paræsthesia are not uncommon. The condition of the tendon reflexes depends upon what portions of the cord are involved. If the lateral columns alone are attacked, they are all increased, in some cases to such a degree that a slight tap on the knee when held in position to elicit the knee-jerk may cause oscillatory movements of the limb and, through the efforts of the patient to control them, involve the trunk, head and opposite side.

In cases which show that the cerebrum is chiefly involved, headache, dizziness, disturbance of the speech, temporary darkening of the visual field and weakening of the memory are among the first symptoms which suggest the gravity of the disease.

Gradually the disease increases in severity, with temporary variations, the preponderance of the spinal or cerebral symptoms depending upon the type of the disease.

After the disease has become fully installed, the patients are almost constantly tortured by various sensory disturbances, such as

severe neuralgic pains, frequently associated with a dull pain located in the deep structures and involving the whole lower half of the body. A slight amount of anæsthesia, irregularly distributed, especially in the lower extremities, at this time also appears. Perhaps the most important symptom, and the one usually regarded as diagnostic, is the so-called "intentional tremor." This consists of a peculiar trembling, which invariably occurs when the patient attempts any voluntary motion, and disappears entirely, or diminishes, when the muscles of the part are again at rest. This is best elicited by causing the patient to carry a glass of water to the mouth. As soon as the glass is raised a series of oscillatory movements commence, frequently causing the contents to be spilled, or, if he is successful in carrying it to the mouth, there is a clattering against the teeth, and if it were not for the support afforded by the mouth the contents would be ejected. At first this may only be seen in the upper extremities, but when the disease is further advanced, all the limbs, as well as the muscles supporting the trunk and head, become involved. The result is that the body, and especially the head, even when the patient is at rest, is subject to a constant tremor, which is greatly increased by any movement. The hands become incapable of any fine mechanical manipulations, the handwriting showing the characteristic tremor which at last renders all writing impossible.

Another prominent symptom is the tonic contraction of the muscles of the lower extremities. This first appears only in isolated attacks of spasmodic extension, which may be produced by exertion or excitement. As the disease advances these attacks become more and more frequent, until a condition of permanent extension prevails, rendering the legs as rigid as sticks and incapable of locomotion. The tendon reflexes are also augmented, and clonic twitching of one or both legs may be excited by passive dorsal flexion of the foot, cutaneous irritation, voluntary movements, and by the acts of defecation or micturition.

Although of rarer occurrence, the same state of contraction may prevail in the upper extremities.

The most prominent of the cerebral disturbances is the so-called "scanning speech," a pronunciation of each syllable separately and distinctly in a slow, drawling and hesitating manner, in a weak, low, monotonous tone of voice, always pitched upon the same key. Later on, certain letters are indistinctly pronounced and replaced by others. In the most intense form the speech may become entirely unintelligible.



In certain cases the symptoms of bulbar paralysis also appear.

The most common of the eye symptoms is that of nystagmus, the eyes being constantly subjected to short twitches in a horizontal direction, and drawn sometimes outward and sometimes inward. These motions may occur persistently or only during forced accommodation, or when a movement occurs in the extremities, the eyes showing nothing abnormal during rest. Amblyopia and diplopia are also found, but less frequently.

More or less psychical disturbance usually appears, varying from slight mental weakening to intense melancholia or pronounced mania.

Perhaps the most constant cerebral symptom is that of vertigo, which may appear among the first signs of the disease and persist during its entire course. The form of vertigo is usually of the turning variety, the patients themselves experiencing a sensation of continual motion, or else the objects about them seem subjected to one persistent gyration.

Another group of symptoms consists of a peculiar form of apoplectic attacks. These attacks are said by Charcot to occur in about one-fifth of the cases. After slight oppression of the head, with more or less mental dulness, the patient sinks into a deep coma. The face becomes flushed, the head hot, pulse very rapid and the temperature rises to  $104^{\circ}$ – $105\frac{1}{2}^{\circ}$  F. Very soon hemiplegia appears, shown by a complete relaxation of the extremities of one side. After one or two days, consciousness returns, the temperature falls, the patient drops into a natural sleep from which he awakens well, with the exception of the paralysis, which usually lasts a few days longer and then entirely disappears. Several of these attacks may occur, or death ensue during the stage of deep coma. When death does not occur, the disease is invariably aggravated by each attack.

Formidable as this array of symptoms appears, the duration of the disease is usually long and tedious. Although some are fortunate enough to die in one or two years, the majority drag out a wretched existence for a much longer period. Some have been known to pass twenty years of this living death, while its ordinary duration is from five to ten years.

Treatment thus far has proven entirely fruitless. All cases in which the disease existed without doubt have ended in death. Whether the future will develop any means of cure more effectual remains to be seen, but the chances of this result seem, at present, very slight.

## A CRITICISM OF THE THEORY OF THE VERTEBRAL FORMATION OF THE SKULL.

BY D. L. SNYDER, M.D., PHILADELPHIA.

THOSE who have had the pleasure of listening to Prof. A. R. Thomas's lectures on anatomy, will recollect his division of the cranium into three vertebræ, or parts corresponding to the same. The illustrious Goethe was probably the first to propound such a theory, and although it contains a spark of truth, yet in the main, it seems almost totally incorrect and open to serious and even fatal objections. Viewing a skull on the inside, we may easily imagine that the occipital bone corresponds to one vertebra, the sphenoid and parietal bones to a second, and the frontal bone to a third. If such an idea of the composition of the skull is correct, it has meaning only in the light of evolution and implies that the brain case has been formed by the enlargement and development of three vertebræ. To assert that such an arrangement has been made simply to carry out a unity of plan, is to make a blank statement of a kind once common with comparative anatomists, which is unsupported by reason and contradictory to the facts of comparative anatomy. In a limited and altered sense, the skull does correspond to vertebræ and is homologous with the same; but truly homologous structures should be homogenetic or derived from corresponding parts. When it is stated that the vertebral theory of the skull is accepted, the thought that naturally arises is that we are to consider that the skull cavity has been formed by the expansion of vertebræ. It is to such an idea that exception is here taken, and not taken because evolution is opposed, but because it is upheld. As criticism on a subject like the one under consideration deserves but little space in a medical journal, brevity will be used even to the extent of endangering the clearness of position, but it is hoped that the remarks made will illustrate a fruitful method of studying anatomy, and in fact, the only one by which it can be understandingly studied. That no such simple explanation as the one given by Prof. Thomas will account for the structures as found, is evidenced by the facts of comparative anatomy, embryology and even human anatomy. In descending the scale of the vertebrate series, who can trace the gradual compression and dwindling of the so-called "skull vertebræ" into vertebræ similar to the remaining ones of the spinal column? and who can show that the early em-

bryonic formation of the skull and spinal column is the same or similar? If the vertebral theory is correct, all facts bearing on the subject should harmonize and support it, but instead of doing so, they seem to antagonize and even contradict it. While comparative anatomists were busy discussing the composition of the skull according to the new theory, Prof. Huxley reminded them of the fact that in the embryonic formation, the skull is not developed from separated and distinct parts but from a sac in which no traces of vertebræ are present. This accords well with the fact that lower vertebrates as selachians and even some ganoids, have a cartilaginous cranium without sections. Ontogeny, being somewhat of a repetition of phylogony, the embryo, accordingly, should not have its skull start as vertebræ but as a structure without divisions. If the idea or theory under criticism is correct, the skull and vertebræ proper, should commence alike and afterwards differentiate. Is it not probable that the resemblance of the bones of the skull to vertebræ is fanciful and accidental? It would seem more so when we recollect that the same division is not made by all anatomists, and some even carry the division into the bones of the face. We might with safety say that our skulls would have been composed of vertebræ had it not been that the developing brain and other causes obliterated traces of the same both in ancestors and embryos. We have facts bearing on the subject which will, in some measure, allow us to form a judgment of the number of segments that would have composed our skulls had this segmentation been allowed to continue or perhaps to commence. A fact of comparative anatomy that is sure death to all former vertebral theories is that our skulls have not been derived from the primitive cartilaginous cranium which alone, if it were segmented, would be homologous with vertebræ, but many bony additions have been added from dermal and mucous structures, which have displaced the primitive cartilaginous skull.

If we should say that the lower jaw is homologous with ribs, we would make the same mistake that the early supporters of the vertebral theory made in regard to the skull, because the lower jaw is not derived from Meckel's cartilage (which is homologous with ribs), but displaces it, the cartilage disappearing. In a similar manner, it would seem, have our primitive skulls been largely displaced in a manner shown by the study of lower forms of fishes. Early in embryonic life there runs a cartilaginous cord along the back of the embryo. It is about this that the vertebræ form and help to segment it. According to evolution principles, it is reproduced by

inheritance from early forms intermediate between vertebrates and invertebrates, somewhat represented at the present day by that most interesting animal the amphioxus. Now we can regard as homologous with vertebræ only those structures that are formed about this notochord; and, as this extends into the occipital and sphenoid bones only, those in front must be regarded as additions, bearing no relation with vertebræ. In the embryo, we have five cartilaginous arches connected with the brain-case, and five vascular arches. As these arches are homologous with ribs, and as we have one pair to each vertebra, we should conclude, from this fact alone, that the number of vertebræ composing our skulls is five instead of three as given by the advocates of the theory under criticism. It completely overthrows the idea that there are only three. If, however, we decide that five is the correct count, we fall into a grave error, because the study of the embryology of fishes reveals the fact that the number of skull ribs is greater than five, and, as in man, some of these disappear before mature development. The number of these arches has, therefore, most likely been diminishing in the upward development of vertebrates, and we receive the intimation that the primitive number must have been quite large, and, corresponding to these, the number of skull vertebræ (if such existed) equally large. It is admitted that cranial nerves correspond to vertebral nerves, and it is so argued by Professor Dalton in his *Physiology*. Leaving out the nerves of special sense, which bear no such relation, we have nine pairs remaining, which number, if none in the course of evolution have become aborted, would be the number of parts corresponding to vertebræ out of which our skulls have been evolved. Here we find support to the intimation given us by the visceral arches, and we are forced to admit that the artificial division of the skull into vertebræ is entirely incorrect and fanciful, it receiving no support from anatomical facts bearing on the subject. The study of comparative anatomy would lead us to believe that some portion of the occipital bone, and, possibly, some of the sphenoid, are derived from structures bearing some relation to vertebræ, but the most of the skull evidently bears no relationship with the same. I hope that the difference of opinion here indicated is more apparent than real, and would even be glad to find that it depends upon a misunderstanding on my part.

## THE WORK OF REVISION BY THE MEDICAL INVESTIGATION CLUB OF BALTIMORE—A CRITICAL ANALYSIS.

BY CONRAD WESSELRHEFT, M.D., BOSTON, MASS.

FOLLOWING out certain carefully elaborated principles stated with their reasons in the *N. E. Med. Gazette* of June, 1886 (*Our Methods of Drug-Proving*), a number of analytical studies based on these principles have been published in that journal under the following titles: "*Rules and Suggestions according to which Provings are to be Tested and Analyzed in Reference to their Validity*," followed by an analysis and summary of cactus and hyoscyamus by Dr. C. Wesselerheft, *N. E. Med. Gazette*, December, 1888.

"Analysis and Summary of Iodine," by Dr. J. P. Sutherland, *ibid.*, January, 1889. The numbers of that journal of August, September, and December contained more or less elaborated articles bearing upon the subject.

It was to be hoped and expected that these initiatory articles would create an interest in a subject which had lain dormant since the beginning of homœopathy, namely, the investigation of the real value of an enormous accumulation of material in the form of provings.

This expectation was realized to a fuller extent than is often the case where an old beaten path is to be abandoned for a new one, presenting many serious difficulties, consisting, in this instance, chiefly of much work which could only be carried on by the united efforts of many.

The work already done by many individuals, bears testimony to the recognition of the reasons advanced for the necessity of the work, as well as to the liberality of methods proposed for the accomplishment of the object.

The work was distinctly inaugurated in 1886, and has progressed for three years without disparagement from any quarter far into 1889, when there appeared in the *HAHNEMANNIAN MONTHLY* of June, 1889, an article bearing the title "*A New and Scientific Materia Medica Based upon Pure Pathogenesis*," by the *Medical Investigation Club of Baltimore*. This article begins with setting forth the importance of "studying and constructing the homœopathic materia medica upon a strictly scientific basis," and without the least allusion to what had already been done, proceeds as if no one had ever thought of such a plan before; furthermore, by adopting the designation

"synthetic," and by laying great stress on the formality of placing an "exponent" (meaning the number of provers corroborating a symptom) over certain symptoms, it endeavors to create the impression that it has discovered the only true plan of work, and attains the only reliable results,—thus justifying the belief in the intention of persuading physicians that the work previously done under the designation of "critical analysis" is all wrong and undeserving of notice. Not until the appearance of the December number of the *HAHNEMANNIAN*, was any notice taken of previous work in critical analysis.

This is not, and never can be made a question of priority. Those who have read, and may yet read, the ample analyses and explanatory articles on this subject, will have no difficulty in deciding this question. What the Medical Investigation Club, of Baltimore, may have thought or intended in 1887 or many years earlier, is of no weight. Literary usage is explicit and inexorable on this point and decides it alone according to the date of its publication.

Critical analysis is not claimed by us as a new invention; it is as old as the world of letters; but its special method of application to the materia medica is ours, and cannot be claimed without unfairness by others, even if they try to express it in other words, such as "synthetic," "new and scientific," etc.

The question of priority being set at rest, we beg to be permitted to turn to the real question, as to whether the "new and scientific" or "synthetic" method differs or is superior to the one previously adopted by us. A brief examination of the objections enumerated in the *HAHNEMANNIAN*, of December, 1889, will, we trust, explain the matter.

Here, as well as in the June article, this method is distinguished by the term "synthetic," and thus made to appear as if it were something new and entirely original, we fear, by placing too much dependence upon the hasty judgment of readers fascinated by such technical terms; for the enlightenment of these, if any there are, be it said that synthetic means putting together, analysis means separating something into its component parts. Hence synthesis or putting together is impossible when the things put together or reunited have never been separated or analyzed. The Investigation Club seems to take special pride in avoiding or concealing its method of separation of chaotic masses for the purposes of examination, and expects that the reader should content himself with what they claim to have reunited in an arrangement which may fairly be styled arbitrary, unless the

reader is told how the parts re-united (synthetically) were found. *This method of seeking for and finding that which is valuable in contradistinction to that which is useless*, is what the student has a right to know, and it is careless or unjust to withhold this information from those who should be enlisted in the work.

The discovery of the useful results of provings, their separation from chaotic accumulations of a century, can only be consummated by some method of separation into its component parts (analysis), by the comparison of these separated parts, as to pathological value; as to pathological agreement (concordance), and as to agreement in mode of expression (congruence). This requires expert knowledge, thought and judgment in the sifting process; this is critical work joined with analysis. After this follows the synthetic summary, and not till then.

One who ignores this, or who, making use of it, fails to describe his method of sifting, also fails in giving his work the proper value of authenticity, and this is the flagrant fault of the "new and scientific method." The reader is nowhere told how the "exponents" were discovered, or, being named, what their real or possible value is.

That no limit is set in the analytical method, either to preparation or degree of subdivision, is made subject of rebuke.

Whatever one may think of high attenuation, he must remember that it has played its part and has influenced the entire history of our school. However emphatically a physician may be opposed to extreme attenuation, he has no other resource in combating it than to disprove it by intelligible reasons and demonstrations. If he cannot furnish these, his opposition will be ineffectual. If he accept the challenge, mere declarations of opinion against it avail nothing.

The probable limit of subdivision demonstrated by the writer and accepted by the Committee of the American Institute (originally in charge of Hughes's *Cyclopædia*, for convenience left in the trustworthy hands of Drs. Dake and Hughes) needs yet further corroboration to satisfy physicians. Such corroboration, that is, the limit of attenuation available in proving, is demonstrable alone by *critical analysis* applied in whatever method a worker may adopt.

The simple principle of selecting that which reasonably agrees, and of rejecting the non-concordant and incongruous, the vague and desultory methods of proving, will and does determine this mooted question, upon the solution of which the progress of pure homœopathy depends. Hence we include in our analysis all provings, and the work has already progressed far enough to demonstrate its value in determining the merits of various potencies.

If these results are to be eventually collected in book-form for general distribution, the analysis of all provings from all potencies must be retained. If in studies for private use, the writer or any one else, being guided by good and valid reasons, excludes from the enormous labor of critical comparison all provings made with attenuations above a certain degree of the scale, he is perfectly justified in doing so, thus avoiding much (to his mind) useless work which, without common consent, cannot be spared the author of a new and scientific materia medica designed for general publication.

It is made to appear as if as a matter of principle Hughes's *Cyclopædia* were set aside in preference for Allen's. This has nowhere been done or intended. The writer, having the honor of being one of the sponsors of Hughes's invaluable work, is the last to discredit a book which is his daily companion; but if it is intended to demonstrate the value of high and low potencies, Allen's work containing records of all provings, constitutes the safest basis for analyses for general publication, aside from the convenience of its arrangement, which in the use of Dr. Hughes's work has first to be made before comparisons are undertaken.

It is not conducive to that degree of harmony which should prevail among unselfish workers in a common field to find themselves ridiculed on account of the many square feet of paper occupied in the making of charts, and to find their form of charts treated as if it constituted an essential feature of analysis.

In the rules and suggestions repeatedly published in the *N. E. Gazette*, June, '86, in December, '88, and in *Transactions of the Institute*, '89, the writer has conscientiously guarded his propositions against the absurd imputation that the form or method of charts suggested is the only and inviolable one; it was there stated, where all might see who would take the trouble, that "in the special method of critically examining a proving *it should be left to each to find his own technical method, but the following is proposed as a guide.*" The writer states, a few lines further on: "These suggestions can be modified, abbreviated or extended by each critic of provings."

The Investigation Club, having simply availed themselves of this general, self-evident privilege, have violated the rules of fair play in harping on the absurdities of the form of charts, particularly inasmuch as they withhold all and every information as to how they obtained their results. There are easy and unreliable methods, and others requiring much thought and labor, which it is more difficult to follow than to ignore or ridicule.



To emphasize the impression intended concerning the absurdity of our humble efforts, the assertion is paraded that "only" the symptoms of three or more provers are to be used, which plan is said to have been modified by Dr. T. F. Allen. This and many other incorrect statements occur, which are herewith submitted to the eminent author referred to for correction.

The words in the original plan (see "Rules and Suggestions," published also in the *HAHNEMANNIAN* and *North American Journal*), are: "*To accept the effects only which are corroborated by numerous tests, of which there should be no less than three.*"

In the face of this perfectly broad and reasonable rule, the statement (No. 4) "that only symptoms that have been experienced by three or more provers are to be used," is a conspicuous distortion of the rule which calls for numerous tests.

If any rules as to percentage were adopted, they were to be, as should be the case with conscientious and earnest workers, temporary and tentative. As for the writer, he committed himself simply to the opinion that the percentage of symptoms to be considered valid should be determined only by careful weighing and comparison of values, the mere clerical enumeration of consonant phrases being quite unreliable.

Next to the claim of the "synthetic" principle of the new *materia medica*, the greatest ado is made about the so-called "exponent," the figure placed at the end of and above a symptom to denote the number of provers by whom it was confirmed. Dr. O'Connor is generously accredited with the introduction of this "feature," which is dilated upon and so often brought to the reader's notice, that it is evidently regarded by the authors as an essential principle introduced by and peculiar to the new "synthetic" method.

The Investigation Club have strangely missed the mark, for in every article written on the subject by the writer and his co-workers, the vital importance of designating the number of corroborative provings is insisted upon, and has been stated and distinctly applied in the explanatory introduction to each drug analyzed, where those who will, can readily find it.

As we are endeavoring to gain co-operation in a new and laborious method of investigating provings, in devising methods of discovering that which is authentic and useful, and of discarding that which is unessential, it was necessary to instruct the learner in the working of our method, and the course of reasoning underlying it, hence the first analyses were given in detail and every comparison broadly ex-

plained in the introduction, where the numbers of corroborative as well as of discordant provings were stated, and where they properly belong in illustrative paradigms.

To place such numbers at the end of a symptom as "exponents," though very useful, is simply a matter of form, not one of principle. The form is a matter of convenience only, the principle of denoting corroborations is vital, and to deny that it has not always been emphasized by us, is not conducive to a fair understanding.

The claims of novelty and originality of the "new and scientific *materia medica*" are so ill-sustained that the most cursory reader familiar with all antecedents, would at once discover that there is nothing new or distinctive in it; not even in regard to the formality of the "exponent."

Our synthetic arrangement is everywhere explained, a matter unaccountably avoided by the Investigation Club. If they repudiate and ridicule our synoptical charts, let them avail themselves of our freely and plainly expressed proposition contained in and promulgated with the writer's earliest plan, to find another and better method of critically examining provings. (See article on "The Use of Charts," *N. E. Gazette*, December, 1889.)

Meantime let the work go on, and if newer and better methods and terms are suggested, they will find ready acceptance, if introduced in a co-operative spirit; but none will assist and many will be repelled by infusing a partisan feeling or monopolization.

In no article has the writer, or those who have kindly adopted his suggestions, insisted that their methods were perfect, but open to improvements; why, then, cannot the Investigation Club of Baltimore assist as others have done and are doing? If so, they will find their labors welcomed by the whole profession.

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### SUPRA-PUBIC LITHOTOMY

(Partial Report of Dr. C. M. Thomas's Surgical Clinic.—Hahnemann College Hospital,  
January 18, 1890.)

THE first case to be brought before you this morning is that of an adult male, under middle age, who has for several years past suffered from stone in the bladder. The presence of this stone has been positively determined by touching it with the instrument known as

the stone sound or searcher, with which most of you are familiar, and I purpose now to remove this calculus by the operation known as the supra-pubic lithotomy. We have, as you know, a number of procedures at our disposal for the removal of stone from the bladder, the special applicability and value of each being determined by a variety of conditions and circumstances. In a general way we may say that a stone may be crushed into fragments and washed from the bladder by the way of the urethra, or it may be removed unbroken through an incision in the bladder-walls. The first method, that by crushing, is known as *lithotrity* or *lithotripsy*; the second, or cutting operation, being called *lithotomy*. Within a few years past, the crushing operation has been greatly modified and improved by an American surgeon, Dr. Bigelow, of Boston, so that instead of carrying out the process in repeated short sittings of a few minutes each, thus removing but a little of the stone at each sitting, the operator is able to break up the stone at once and immediately remove the fragments by means of suitably constructed urethral tubes and pumps. This special method has been called by its originator, *litholapaxy*, and has almost entirely superseded the old method. By this operation, under favorable conditions, stones of considerable size may be crushed and removed at one sitting. Litholapaxy is applicable to all cases occurring in adults, or at least adolescents, where the stone is freely movable and not of *great* size, unless it be soft in structure. A roomy urethra is naturally a necessity in this operation on account of the large size of the instruments required in its successful performance. In suitable cases, there is no operation for stone so perfect in its immediate results or so safe; its mortality-rate being probably as low as 6 per cent. No cutting operation shows so low a percentage excepting the lateral incision through the perinæum, and this only in the case of young children, where its death-rate is even lower than that of litholapaxy, being somewhere about 3 per cent. The general mortality of the lateral operation, including all ages, is, however, far from being so favorable, running probably as high as 25 per cent. The only other cutting operation through the perinæum is that known as the median lithotomy, in which the neck of the bladder is reached by incision through the raphe of the perinæum; its death-rate is low, not reaching 10 per cent., but its application is limited to stones of small size. The only remaining procedure necessary for me to consider is the so-called high operation or supra-pubic lithotomy in which the bladder is opened at its fundus through an incision in the abdominal wall just above the pubes. Until within

a comparatively few years this operation was reserved for cases of enormous calculi, and those in which the perineal methods had failed, and, in consequence, its death-rate was far above even the lateral lithotomy. Of late years this method has been rapidly growing in favor and, more especially since the introduction of antiseptic surgery, its death-rate has steadily lowered, until now it stands, for medium and large stones and all ages, decidedly below that of the lateral perineal operation. Its death-rate is probably less than 15 per cent. In the hands of some operators it has been much lower than this. A Russian surgeon has recently reported a hundred cases without a death. For very hard, large or encysted stones it is certainly superior to any other procedure.

To briefly recapitulate, I am fairly safe in saying that the large majority of surgeons of the present day would place the indications for choice of operation as follows :

*Litholapaxy*, for adults with capacious urethras, small and medium sized, even hard stones which are freely movable in the bladder, and stones of large size, if they be soft.

*Supra-pubic lithotomy*, for all ages, and when from the pocketing of the stone, its large size, great density, or when, from an irremediable narrowing of the urethra, the litholapaxy is ruled out.

*Lateral lithotomy*, especially adapted to removal of medium sized stones in young children, where it may still rival the high operation.

*Median lithotomy*, to be limited to extraction of small stones, which for some good reason cannot be safely crushed.

In the case now being etherized, although he has a capacious urethra and a movable stone, I am obliged, as you see from what I have said, to rule out the crushing operation, from the fact that upon grasping the stone at random with the lithotrite I find it measures in one diameter nearly two inches, and the bite of the lithotrite blades upon it gives me the sensation of extreme hardness. The stone being hard and above the average in size, and the patient an adult, I further do not hesitate to rule out the lateral lithotomy, and shall now proceed to remove it by the supra-pubic method.

The patient, as you see, is placed upon his back, with the pelvis raised upon a firm cushion. Through a flexible catheter, the bladder is now emptied, and washed out with pure hot water; then this rubber bag is introduced well into the rectum, and distended with about four ounces of water. Through the catheter I now inject slowly ten or twelve ounces of water into the bladder; this disten-

sion of the organ usually showing itself on palpation just above the pubes. I now further distend the rectal bag, until it holds eight to ten ounces. The object of using this rubber bag is to force the filled bladder upward out of the pelvis and thus elevate the line of peritoneal reflection from the fundus of bladder to a greater distance above the pubis.

I now make an incision immediately over the bladder in the middle line, about three to four inches long, the lower extremity of which reaches well down on to the front of the pubes. The first stroke of the knife divides the skin and fat, and exposes the linea alba, which is slit up for about two and a half inches; the knife, now passing down between the pyramidales muscles, divides the transversalis fascia beneath them. The parts thus far divided being separated by blunt retractors, we expose the layer of fat called pre-vesical, which lies over the front of the bladder. This fat is nicked close behind the pubes, and, with the point of the left index finger, torn off from the face of the bladder-wall and displaced upward toward the upper angle of the wound. As a rule, the peritonæum is not seen, but occasionally its line of reflexion from the bladder will be found lying with this fatty tissue, and will have to be displaced with it. In one of my cases, after dividing the transversalis fascia, I found the peritonæum, with enclosed loops of intestine, close down against the pubic bone, from which it had to be peeled back with much care to avoid injury. The top of the bladder-wall now appears as a firm, brownish-pink, striated, elastic surface. After tying all bleeding points in the cut, I now pass a medium-sized silk ligature on a curved needle through the bladder-wall near the upper angle of the wound, which will give me control of the bladder and prevent its dropping out of reach after incision; immediately below this point I plunge a bistoury through the walls of the organ, cutting downward toward the pubes for about an inch and a quarter. My left index finger quickly follows the knife into the interior, checking the gush of water through the cut, and comes immediately in contact with the stone, which I find to be a very large, flat one. Having flushed the bladder and wound with hot water from the irrigator, I now introduce along my forefinger a pair of stone forceps, with which the stone is easily extracted after slightly enlarging the bladder-wound with the knife. As you see, this stone is considerably above the average in size, and probably of the hard or uric acid variety, thus fully justifying us in the selection of the high operation

for its removal.\* I now thoroughly irrigate the bladder and wound with a weak bichloride solution and close the opening in the bladder with a double bank of fine silk sutures. The first of these stitches are interrupted, and placed about a quarter of an inch apart, care being taken that the needle is passed down to, but not through the mucous coat, the second row being a continuous suture. I may say here that the advisability of suturing the bladder in this operation is still an open question among surgeons, many claiming that primary union being uncertain, the risk of infiltration and septic infection is much increased by attempting it, while, with a completely open wound, there is but little danger of retention of discharges. When the whole extent of the wound up to the skin surface is tightly closed, this view is certainly correct, but, it seems to me, that the practice of Bergmann of Berlin, which I have adopted successfully in a number of cases, and shall carry out here, renders the bladder suture in appropriate cases comparatively safe and certain. Following this method, you will notice that the space from the bladder-wall to the skin surface is lightly filled with iodoform gauze, but no attempt is made to bring the skin together, so that should the suture give way, the urine and any septic material will find free vent, and the wound then be treated entirely as an open one, while, if it hold and all goes well, the packing may be removed after a few days, leaving the external wound to heal by granulation. Where the bladder is foul, the patient old and decrepit, or the bladder-walls much bruised in the extraction of the stone, the suture is certainly contra-indicated. In adults where the suture is used, an in-lying soft catheter prevents accumulation of urine and over-distension of the bladder, but may be usually dispensed with after ten days; in children, as a rule, voluntary urination may safely be encouraged from the first. Where the wound is left entirely patulous, an in-lying catheter is quite useless, since the urine, as fast as it enters the bladder, flows out by the wound and will not pass through the catheter while the fundus of the bladder is gaping. The after-treatment in cases not sutured, consists in simply keeping the wound clean by frequent irrigation, allowing the patient to lie in any position most comfortable to him, preferably, however, upon either side towards the face.†

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\* The stone weighed three ounces, and measured in its three circumferences, respectively,  $6\frac{1}{2}$  inches,  $7\frac{1}{2}$  inches, and  $5\frac{1}{2}$  inches.

† The patient was presented to the class two weeks later, with primary union of the bladder, voluntary urination, and a healthy granulating wound of the abdominal walls. He was discharged in the fourth week, entirely well.

## PROCEEDINGS OF SOCIETIES.

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### THIRTY-NINTH ANNUAL MEETING OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF NEW YORK.

THE Homœopathic Medical Society of the State of New York convened in the court room, City Hall, Albany, N. Y., at 10.15 o'clock, February 11, 1890. The attendance was not large, but it comprised delegates from all the judicial districts in the State of New York.

The Society was called to order by the President, Dr. Herbert M. Dayfoot, of Rochester. Prayer was offered by the Rev. Mr. Foster.

#### THE INTRODUCTORY ADDRESS.

President Dayfoot delivered his introductory address. He welcomed the delegates to the annual session, spoke of the pleasure in thus coming together, paid a tribute to the memories of those who had died during the year, and referred to the proceedings had at the semi-annual meeting. Among the resolutions adopted at that meeting was one urging increased vigor in the organization of county societies. It was necessary that every homœopathic physician should become a member of the society in the county in which he resides. Referring to the action of the semi-annual meeting sustaining the previous action of the State Society regarding State boards of medical examiners, the President had this to say with reference to that subject and the war between the homœopathic and allopathic schools of medicine:

"This question is to-day by far the most important matter that we shall have presented for consideration. This question involves the life or death struggle of the homœopathic school. There are two bills before the Legislature designed to create boards of medical examiners. One presented by the allopathic school provides one board. The other, presented by the homœopathic school, provides three boards, one for each of the incorporated schools of medicine.

"Provision is made in the allopathic bill for the representation of the three incorporated schools of medicine, the basis of representation, however, being unequal as regards numbers, the allopathic school retaining a majority thereof. At the meeting of the Allopathic Society, held one week ago, the specific form of majority membership named in their present bill was dropped, and the wording of the first section ordered to be changed, so as to allow the Board of Regents to select appointees as they may deem best.

"This shifting of the responsibility of obtaining majority membership from themselves to the Board of Regents, does not afford the

homœopathic school any additional security from the danger of allopathic control, and is not designed to. The allopathic school is determined to secure the single board, and to obtain control thereof, either by the express provisions of their bill or through the instrumentality of the regents. In either case the danger to the homœopathic school is equally great. This change, however, has been forced upon the allopathic school. It has not been made willingly; but on account of the disapproval on the part of the public already expressed against placing the members of one school under the control of another. It is the merest makeshift, designed to blind the public, without giving up a particle of the power they intend to acquire and use to the disadvantage of the homœopathic school, by means of the single examining board, the single board being their only resource for obtaining complete control of the licensing of homœopathic students.

"The manifest unfairness and illiberality of the allopathic bill may be seen at a glance. Under the plea of elevating the standard of medical education, they are seeking to place us and our school in a position of subserviency, and rob us of the civil right to license our own students. It has evidently not occurred to the framer of this bill that results to some, at the expense of civil rights to others, will be more than extortionally compensatory; that we are ready in separate bands to hold up the standard as high as the old school dares to, and to make legal arrangements and provisions for it through consultation and the adoption of a uniform examination; that if this is the only end sought there is no reason why the old school should have a majority representation in a single board; that to assume the other schools will lower the standard is a gratuitous, if not insulting, assumption.

"That the homœopathic profession is a unit in sentiment in opposition to this centralizing and arbitrary scheme is shown by the fact that the separate board system, as embodied in the first section of the homœopathic bill (Senate 50) has been endorsed by every homœopathic medical society, State and national, in this country, and the faculties of all the homœopathic medical colleges.

"We must not for an instant lose sight of the fact that the allopathic school is intent upon securing the single board, as its only method for obtaining a hold upon our school; and also that our only hope of freedom therefrom is the establishment in this State of the separate board system.

"While we are equally solicitous with the allopathic school to raise the standard of medical education in order to protect public interests, we recognize the fact that we are equally capable of judging as to a proper standard of medical attainment, hence the public will gain nothing by giving the allopathic school control of the single board; on the contrary, public interests will be jeopardized and impaired by practically confining to one school licensing powers which properly belong to each equally. We demand in terms most posi-



tive and unmistakable, the free exercise of civil right to license our own students.

"At their meeting held last week the allopathic school endorsed the single board bill (Senate 115), by means of which they can obtain power to be used against the homœopathic system, and at the same time, while denouncing the use of the name as a trade-mark and as advertising business interests, they approved a proposition to enter upon the teaching of homœopathic principles and practice in their medical colleges. Pardon us, our friends, the enemy, if we refrain from swallowing this sugar-coated pill. It can be considered none other than a sop to Cerberus; the dog, however, had three heads; we also desire three boards; besides, the sugar-coating is thin and the contents unpalatable, while our pills are homogeneous.

"Then, too, what a boon it will be to have students acquire a knowledge of homœopathic principles from those who have repeatedly declared the system a myth; from those who have sought to ostracise it and deprive it of its distinctive name; in fact, from its enemies. As consistently might we expect to obtain a knowledge of the principles of republicanism from kings; of those of free trade from protectionists; or of theology from the devil.

"If, however, these allopathic medical colleges shall set about the teaching of homœopathic principles in good faith, and shall select instructors from the membership of the homœopathic school, legally qualified and recognized homœopathic physicians, we will accept such evidence of good will and sincerity of purpose, tender our congratulations to them on having progressed to an acknowledgement of the truthfulness and trustworthiness of homœopathic principles, feeling assured of additional convincing evidences of proximity to the medical millennium."

After the reading of the President's Address, the following committees were announced by the President:

*President's Address.*—Drs. W. M. L. Fiske, Brooklyn; E. S. Coburn, Troy; A. B. Norton, New York.

*Credentials.*—Drs. L. A. Bull, Buffalo; George E. Gorham, Albany.

*Auditing.*—Drs. W. B. Gifford, Attica; D. B. Stumpf, Buffalo.

*Finance.*—Drs. E. S. Coburn, Troy; George M. Dillow, New York; George W. Lewis, Jr., Buffalo.

*Regents.*—Drs. S. N. Brayton, Buffalo; E. Hasbrouck, Brooklyn; George E. Gorham, Albany.

The minutes of the last meeting were then approved as printed, after which the Committee on Credentials reported these delegates present from other societies; Dr. George B. Peck, of the Rhode Island Society, and Dr. W. W. Van Baun, of the Pennsylvania Society.

The following were elected members: W. F. Clapp, Fairport; J. H. Hallock, Syracuse; Edwin S. Hayward, Julia F. Haywood, George M. Haywood, John H. McCullum, C. W. Perrine, J. S. Read, Marcena E. Sherman, O. S. Stull, Rochester; H. J. Pierson, G. H. R. Bennett, W. W. Blackman, L. W. Bolan, A. H. Elliott, D. A. Gorton, F. Percy Jenks, C. A. Walters, J. L. Watson, J. H. Ward, N. Robinson, E. H. Muncie, Chauncey E. Low, C. L. Johnston, George P. Cornell, Brooklyn; C. A. Ward, F. L. Stacy, Binghamton; R. R. Trotter, Yonkers; J. W. LeSeur, Batavia; J. S. Halbert, Buffalo; C. A. Rowley, Victor; F. E. Roper, Deposit; Charles F. Otis, Honeoye Falls.

Dr. Arthur B. Norton, Treasurer, presented his report. This showed a balance on hand at the last report of \$385; receipts during the year, \$1004.60; total, \$1389.60. The disbursements were \$1007.78, leaving a balance on hand of \$381.82. Dr. Norton, however, naively added that a bill of \$536 for printing yet remained to be paid out of the balance. The report was received. The treasurer also reported a list of members in arrears for dues.

Nominations for office being next in order, Dr. George W. Lewis, in a few eloquent remarks concerning his erudite and scholarly attainments, presented the name of Dr. George W. Dillow, of New York, for President. The nomination was seconded. Drs. N. B. Covert, of Geneva, and William E. Millbanks, of Albany, were nominated, respectively, for first and second Vice-Presidents. The balance of the nominations were referred to a committee, consisting of Drs. W. M. L. Fiske, of Brooklyn; Charles E. H. Brayton, of Rochester; L. A. Bull and D. B. Stumpf, of Buffalo.

#### DEMANDS OF THE HOMŒOPATHS.

Dr. H. M. Paine, of Albany, read an exhaustive report from the Committee on Legislation, of which he is chairman. It gave a review of all that the committee had done to forward legislation that would equally recognize homœopathy with allopathy and in opposing the single board systems. He submitted the

#### CORRECTED RESOLUTIONS.

*Whereas*, The allopathic school in this and many other States in this country is intensely engaged in prosecuting a movement for securing the enactment of laws providing State examining and licensing boards, which laws are adroitly arranged so as to acquire for their own school complete control of the licensing of the students of the eclectic and homœopathic schools of medicine; and

*Whereas*, Such power centralized and possessed by the allopathic school would, most assuredly, be used disadvantageously toward the homœopathic and eclectic schools, notwithstanding the pretended support afforded by minority representation therein; and

*Whereas*, It is one of the foundation principles of sound government, that all legally organized bodies of its citizens shall possess the constitutional right of self-preservation and perpetuation; therefore

*Resolved*, That in the opinion of this Society the principles represented by the *single* examining and licensing board system are contrary to sound government, and destructive in their tendencies to the schools having minority representation therein.

*Resolved*, That we are unalterably opposed to the passage of Senate Bill No. 115, presented by the allopathic school, the construction of which provides for the appointment of a single examining and licensing board.

*Resolved*, That as the single board system necessarily involves allopathic control, whether the relative number of members is specifically stated in their proposed bill or left discretionary with the regents, the danger to homœopathic interests is as great in one case as in the other.

*Resolved*, That we protest against any legislation providing a single examining board, as an infringement of our civil right to supervise and maintain our own educational affairs, and as an unwarrantable attempt to transfer our responsibility for the quality of our educational work from the people, where it properly belongs, to the allopathic school, without any adequate reason and without any apparent necessity.

*Resolved*, That we heartily indorse Senate Bill No. 50, and Assembly Bill No. 234, provision being made therein for the appointment of separate examining and licensing boards for each of the incorporated schools of medicine, and hereby pledge ourselves to put forth every suitable effort for securing its adoption.

The report and resolutions were unanimously adopted.

The Bureaus of Mental and Nervous Diseases, Vital Statistics and Climatology failing to report, the Society adjourned until 2.30 P.M.

AFTERNOON SESSION.—The Bureau of Pædology was the first to report. Two papers were read: "Congenital Nævus and its Treatment," by Leslie Martin, M.D., and "Observations on the Epidemic Influenza in Children," by Drs. Sheldon and Candee.

The writers considered that notwithstanding the prevailing idea that children were not subjected to the epidemic influence, that young children were frequently attacked, the cases being mild and escaping observation. The forms of the disease occurring in children were

three—gastric, nervous and catarrhal. The sequelæ were analogous to those of scarlet fever, some of the severer conditions following mild cases of the grippe. Treatment: Absolute rest, good hygienic surroundings, patients to avoid night exposure for three or four weeks, and the indicated remedy, such as *aco.*, *bell.*, *nux vom.*, *puls.*, *gels.*, *colocynth.*, *ars.*, *ars. jod.*, *allium cepa*, *tart. emet.*

Adjuvants—Bovine and unfermented grape juice.

The Bureau of Materia Medica presented two short interesting papers by Dr. Wm. F. Honan:

1. "Over-dosing with Fowler's Solution of Arsenic."

2. "Symptoms from Inhaling and Swallowing Chlorine."

And a valuable paper by the bureau chairman, Dr. M. W. Van Denburg, on "Construing a Drug Disease."

The Bureaus of Obstetrics and Gynæcology failed to report.

Dr. S. F. Wilcox, the chairman of the Bureau of Surgery, being absent, Dr. De Witt G. Wilcox took his place, and read an important paper on "A Case of Compound Fracture of the Ankle-joint, involving the Tibia and Fibula," by S. F. Wilcox, M.D. This was followed by a paper on "The Treatment of Hæmorrhoids and Rectal Fistulæ by Electrolysis and the Galvano-cautery," by Dr. William H. King. This paper called forth an animated discussion.

The Doctor stated that hæmorrhoids had formerly been treated by electrolysis which had fallen into disuse because its results were not permanent. The reason of this was, that the negative pole of the battery was used to produce the clot. He advises using the positive pole by introducing a needle into the base of the hæmorrhoid, and producing a clot at its base which completely shuts off all circulation in the tumor and changed it into a hard mass. The galvano-cautery treatment he recommended, was to sever the hæmorrhoidal tumor with the galvano-cautery *écraseur*. He spoke of a treatment for fistula in ano devised by Dr. W. S. Shotwell. It was as follows: He places a rectoscope in the rectum so that the opening comes next to the internal opening of the fistula. He now introduces into the fistulous sac a probe, which has a small opening in the end that is introduced. If the sinus does not quite open into the rectum, he perforates the intervening tissue with the probe until the eye in the instrument comes into sight. He next introduces a lance-pointed probe about three-eighths of an inch farther from the anus, into the solid tissue and parallel with the other probe. This also, has an eye in the end introduced, and, as both probe and lance are now introduced so that these openings can be seen in the rectum, the two ends of a No. 24 platinum wire are fastened in them and the probe and lance are withdrawn, thus forming a loop with the wire. The two ends of wire are now attached to the two electrodes of a battery

which is connected for quantity so as to get slight cauterly effects. The current is turned on and the loop allowed to gradually cut its way through the tissues.

The Bureau closed by the reading of a paper on "Bone Suturing," by Dr. De Witt G. Wilcox (See page 137).

The Bureau of Histology did not report.

The Society, after electing to membership Drs. F. W. Kestindike, Brooklyn, and W. H. Sweating, Savannah, N. Y., and finishing some routine business, adjourned until evening.

**EVENING SESSION.**—The evening session was devoted to an address by Conrad Wesselhœft, M.D., of Boston, on "The Relation of Homœopaths to their own School, to the Old School, and to the State." His remarks dealt largely with the pending bill providing for a State medical examining board. The speaker said in substance:

There are many ways of furthering the interest of our school—mentioning three, viz., the consideration of the relations of our school to the State, of its relation to the old school, and of its members towards each other.

The question now uppermost in the minds of members of the New York State Homœopathic Society is that in regard to the establishment of examining and licensing boards. The need of such boards is generally admitted, but you claim that each school should have one for itself for the sake of fairness.

The experience regarding the necessity for such boards in Massachusetts was related, and its failure ascribed to the prevalence of the quack element on the one hand, and on the other the conservative attitude of homœopathists who refused to take part as long as they are not recognized or approached in a generous and friendly spirit by the old school.

Separate boards, said the speaker, are an expediency tentative and temporary, but necessary only if college diplomas are not deemed sufficient guarantees of proficiency, and as long as the old school unjustly persists in demanding the abandonment of our rights to our title.

Aside from this, would not separate boards tend to draw the partisan line more closely, and preclude, on the part of applicants, the necessary knowledge of all systems of practice?

They would also tend to open the door to other boards should other schools arise, as is possible in the future.

To aid in the future approximation of schools, certain concessions are to be made; by the old school our right and title to our method, and on our part that our method is claimed as one by the side of other methods, and that it is non-exclusive.

The speaker dwelt on the error of the old school in concealing methodically any knowledge of our method of practice, and hoped that colleges pursuing this course in future would be deemed illegal.

He considered the keynote of the question to be that all applicants should be examined in all systems, and that those of the old school must, in future, submit to examination in ours; failing in which, we shall be justified in resisting, by every means, all our common examination by boards controlled by them.

The closing part of the address related to the higher and more essential means of furthering our progress, namely, by placing the axiom of similars (S. S. C.) on a firmer basis by inductive experimental research, in place of the ancient basis of deductive generalization.

The pharmacy of our school needs to be freed from errors leading to mysticism, as illustrated by researches on trituration and dilution, and the limited divisibility of matter.

Lastly, our *materia medica*, an accumulation of insufficiently asserted observations, needs to be properly sifted by the method of critical analysis, in which considerable work has already been done.

## SECOND DAY.

The Bureau of Otology was called for. No report.

Owing to the absence of Dr. Charles C. Boyle, chairman of the Bureau of Ophthalmology, Dr. A. B. Norton, took charge, and first read a paper on "Two Cases of Glaucoma," by Dr. Boyle:

The doctor reported two cases in which the progress of the disease had been checked, and the sight restored by medicinal treatment.

CASE I.—A lady, sixty-four years; sight failing for six months;  $+ 2 = \frac{2}{8}$  R. E.  $= \frac{3}{8}$  L. E. Gelsemin. 1x internally and eserine in solution 1-200, instilled in eyes, was followed by immediate and marked improvement. On the seventh day vision was  $\frac{2}{8}$  in both eyes.

CASE II.—A woman, whose father had lost an eye by glaucoma. The woman had severe pains on and off in eyes lasting for three months, accompanied by frequent blind spells. Vision, R. E.  $\frac{2}{8}$ , L. E.  $\frac{2}{8}$ . Left optic nerve cupped. Treatment and results same as in first case. Dr. Boyle considered that gelsemin. relieved the nervous tension and caused the absorption of the hyper-secretion.

In the discussion, Dr. F. Park Lewis thought that glaucoma was a neurosis, the character of which was still to be determined. The value of gelsemium had long since been pointed out, and it was gratifying to have it confirmed. To relieve intraocular tension, he used

osmium with gratifying results, especially after iridectomy with high tension, giving  $\frac{1}{800}$  of a gramme, repeated hourly. In moderate glaucoma, tension + or + 1 without positive loss of sight, osmium in his hands has been very beneficial.

Dr. F. Park Lewis read a paper on "Notes on the Extraction of Cataract," summarizing his experience as follows:

Aside from constantly increasing technical skill, he attributed the better results now obtained in this operation first, to the introduction of local anæsthesia; second, to the more general adoption of anti-septic measures; and, third, the return to the simple extraction.

After noting the difference of opinion among ophthalmologists concerning the extraction without iridectomy, among the chief advantages in its favor he placed: 1st. The absence of any disfiguration. This may not be noticeable in those whose eyes are dark, but in light irides the iridectomy is more noticeable. 2d. The absence of pain. 3d. The cleanliness of the wound, and consequent more rapid healing. 4th. The better visual results.

The *objections* to the simple extraction noted were: 1st. Its greater difficulty. 2d. The danger of prolapse of the iris. 3d. Its impracticability in certain conditions. Interesting cases were cited in demonstration of these points, and the conclusion reached was, that the operation must be determined by the conditions of the case. These cannot always be foretold, but where applicable, the simple extraction is the safest, the best, indeed the *ideal* operation for cataract.

The next point to which the doctor called attention is a little manoeuvre which has greatly lessened the number of his operations for secondary cataract. That is *immediate division of the posterior capsule with the cystotome after the extraction of the lens*.

A secondary capsulotomy is not always free from danger, but by means of this operation, which is quite simple, the necessity for subsequent needling was avoided in all the cases so treated.

A simplified dressing was then mentioned. The ordinary bandage is apt to be uncomfortable, and is easily displaced. The isinglass plaster is useful, but fails to give the sense of security which the patient desires.

A compromise has proven most satisfactory. A fold of cotton or linen cloth, lightly spread with vaseline, is laid over the closed lid, and the orbit filled with antiseptic cotton. An adhesive strap is then passed from temple to temple, if both eyes are to be protected, or from brow to cheek if but one. The simplicity of application, the ease with which it is removed, and the complete feeling of security which it gives the patient, makes this a most satisfactory protective, not only after cataract extraction, but in general surgery of the eye as well.

Dr. A. B. Norton presented a paper on "Keratitis Parenchymatosa."

The Society then proceeded to routine business.

Dr. H. M. Paine, of Albany, offered the following resolution :

*Whereas*, The recent report of the State commission in lunacy makes a powerful and convincing presentation of the evils and dangers inseparable from the so-called "county care system" of treatment for the indigent insane; and whereas the bill to provide for the abolition of that system and for the transfer to State asylums of all the present insane inmates of county poor houses has been or will soon be again brought before the legislature for its action, therefore be it

*Resolved*, That this Society, representing the homœopathic medical profession, and expressing its deliberate convictions both as practitioners and as citizens solicitous for the honor and true welfare of the State, does earnestly advise and recommend to the honorable, the legislature, that the bill above referred to, be passed by it at its present session.

We particularly recommend that the bill in question be made to provide for all the insane of the State, of whatever consideration in life, and we also recommend that the proposed law provide for those who prefer homœopathic treatment the privilege of being sent to the Middletown asylum, even though they reside outside the district allotted to that asylum.

We believe it to be a measure of the highest importance to the needs and conditions of the indigent insane, and its early enactment seems to be required as well by the demands of humanity and decency on their behalf as by regard for the material interest, the moral progress, and the dignity and character of the State itself. Adopted.

Another resolution to the same effect, offered by Dr. Paine, was adopted, as follows :

*Resolved*, That the Committee on Medical Legislation be instructed to secure an exemption of the homœopathic asylum at Middletown from any rigid district allotment, so that in case the friends of any patient, in any part of the State, shall express a desire for homœopathic treatment, the same provision which now holds for the commitment of the insane to this asylum may be continued.

Dr. Talcott described the purpose of the bill now pending in the Legislature, recommended by the State Lunacy Commission. He added that there were four hundred and eighty private patients in the asylums of the State, and while provision was being made for the thousands of indigent insane under the care of county superin-



tendents, provision should also be made for the wealthy insane in the same connection.

The report and resolutions were adopted.

The nomination of Dr. Elliott Colburn Low, of Plattsburgh for Regent's degree was confirmed.

Dr. Clarence Bartlett, of Philadelphia, was elected an honorary member of the Society.

Dr. Henry Paine, of New York, was elected a senior member of the Society.

The election of officers for the ensuing year was then taken up. The Chair appointed Drs. Sheldon and Wilcox tellers. These officers were elected :

President, Dr. George M. Dillow, of New York ; First Vice-President, Dr. N. B. Covert, of Geneva ; Second Vice-President, Dr. J. M. Lee, of Rochester ; Third Vice-President, Dr. W. B. Gifford, of Utica ; Secretary, Dr. John L. Moffat, of Brooklyn ; Treasurer, Dr. Arthur B. Norton, of New York.

Censors.—Northern District, Drs. W. H. Nickelson, H. M. Paine, S. T. Birdsall ; Southern District, Drs. W. M. L. Fiske, L. L. Danforth, J. J. Mitchell ; Western District, Drs. H. M. Dayfoot, L. A. Bull, S. W. Brayton ; Middle District, Drs. Louis Faust, A. B. Kinne, F. F. Laird.

The following were appointed chairmen of the various Bureaus: Surgery, De W. G. Wilcox, of Buffalo ; Materia Medica, W. M. Decker, Kingston ; Clinical Medicine, J. M. Schley, New York ; Gynæcology, George E. Gorham, Albany ; Ophthalmology, Charles Helfrich, New York ; Otology, N. B. Covert, Geneva ; Histology, R. R. Trotter, Yonkers ; Mental and Nervous Diseases, J. T. Greenleaf, Owego ; Obstetrics, H. M. Dayfoot, Rochester ; Pædology, George F. Hand, Binghamton ; Laryngology, Charles E. Jones, Albany ; Vital Statistics, T. Franklin Smith, New York ; Climatology, H. L. Waldo, Troy.

It was decided to hold the next Semi-annual Meeting at Brooklyn, on September 31st and October 1st, 1890.

The Chair then appointed the Committee on Legislation, as follows: H. M. Paine, Albany, Chairman ; Asa S. Couch, Fredonia ; S. H. Talcott, Middletown ; J. W. Sheldon, Syracuse ; George E. Gorham, Albany, and J. M. Schley, New York City.

The report of the Bureau of Laryngology being called for, Dr. George M. Dillow, Chairman, read a paper on "The Treatment of *La Grippe*," by Louis A. Bull, and one on "Three Cases of Acute Thyroiditis," by Irving Townsend.

Under the Bureau of Clinical Medicine the following papers were read by title: "Some of the Difficulties in Diagnosing Mild Attacks of Diphtheria," by Dr. J. M. Schley. "Static Electricity," by W. H. King, M.D. "Clinical Notes on an Old Antiseptic," by M. W. Van Denburg, M.D. And "The Sequelæ of Measles," by C. E. Walker, M.D.

In the latter paper the author claimed that such diseases as scrofula, rachitis, phthisis, tubercular meningitis, bone and joint disease, may lie dormant in the system; that the seeds or germs of such diseases lie in a state of dormant vitality which, according to facts and experience, have been roused to activity by measles. Such diseases would be the sequelæ proper. The sequelæ of measles are those maladies which arise in consequence of it, and remain after its termination as an independent disease, or which appear for the first time after measles without being immediately due to any complication of the same. He claimed that an acute disease occurring at the same time, and in the same individual, with a chronic disease, the latter will be materially affected for the better, and oftentimes eradicated. There are numerous recorded cases to substantiate this statement. Especially is this seen in chronic skin affections and nervous diseases. The paper closed with the following conclusions:

(1). Measles, while a common complaint, is by no means a trivial one.

(2). It should be considered one of the most important exanthems.

(3). The morbid influence of measles is most profound. It has the power to rouse into activity hereditary diseases, the seeds of which have hitherto lain dormant.

(4). Measles furnish a fit soil for the development of latent diseases.

(5). Measles have the power, when the human system is already actively influenced by a disease, to so disturb the condition of things that the chronic affection dies out, or, is materially mitigated.

The reports of Bureaus were then closed. A heart-felt vote of thanks was extended to the retiring President, Dr. Dayfoot. The meeting then adjourned.

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## CORRESPONDENCE.

### HOMŒOPATHY IN ALABAMA.

TO THE EDITORS OF THE HAHNEMANNIAN MONTHLY:

In his article in February number, on unjust medical legislation, Doctor H. M. Paine says:

"The reason why the homœopaths of Alabama are now put to such severe straits is simply because they have allowed the allopathic leaders to obtain complete legal control of *the civil right of licensing.*"

The Doctor does not know that when this Alabama medical law was engineered through the legislature by the fifteen hundred allopaths of the State, then, as now, perfectly organized, it contained but two with a possible third—homœopaths. The eclectics numbered thirty or forty. They are organized into a prosperous society with which the homœopaths have united in the fight for justice.

Though the average of success in the required examination favors the homœopaths, as far as my observation extends, I have known of several instances where the law kept some mighty poor homœopaths out of the State. I recollect with pain one ludicrous failure in the person of a graduate of one of our leading homœopathic colleges. This gentleman's first subject was anatomy, and he sat under the examiner's eye for two hours, alternately sharpening his pencil and biting its end off, squirming nervously in his chair the while. He then left the room and the town.

He had written just two words, and in answer to the question, "Describe the Circulation of the Brain." They were, "Circula Willis." The inference was, that either the college had sadly erred or the gentleman's "Circula Willis" was too small in calibre to supply his brain cells.

But to my subject; Dr. Paine's quotations show plainly that there is now no penalty affixed to the breaking of this law at present, and if homœopaths will flock to the State before such penalty is affixed, the strength for the fight will be forthcoming when needed, to say nothing of the money which I believe every homœopath in these United States would subscribe.

Alabama would be an El Dorado to the homœopaths. The people resent having allopathy crammed down their throats, and are in sympathy with us, and *Vox Populi, est Vox Dei*.

Herein, it seems to me, lies the solution of this problem:

The Southern Association meets at Birmingham next November, and then will be offered an opportunity for Northern men who desire to investigate the South as a location to do so at reduced railroad and hotel rates, and to converse with the leading Southern physicians upon the subject.

The manufacturing cities of Alabama are growing like magic, are filled with mechanics and skilled laborers on good salaries, and contain many Northern people,—and more every month,—who seize with avidity the first opportunity to obtain homœopathic practice. In practical proof of this I will speak briefly of my own experience. I located in Birmingham in 1882; was young and comparatively

inexperienced, and had not a single acquaintance in the city, which contained then but nine thousand people. Through a modest sign and a card in the paper my collections for the fourth month after arrival amounted to over \$200, and this before the people had possibly had time to test my value as a practitioner. I only mention my own experience in this connection, because it is the most familiar to me. The principal manufacturing cities of Alabama are (and I can only approximate population as they grow every day):

	Popula- tion.	Homœo- patha.
Birmingham, . . . . .	50,000	2
Anneston, . . . . .	20,000	0
Bessemer (4 years old), . . . . .	10,000	0
Florence, . . . . .	10,000	0
Sheffield, . . . . .	5,000	0
Gadsden, . . . . .	6,000	0

The other cities are :

	Popula- tion.	Homœo- patha.
Montgomery, . . . . .	30,000	1
Mobile, . . . . .	40,000	1
Selma, . . . . .	12,000	0
Tuscaloosa, . . . . .	4,000	0

The first the capital; the second the seaport; the third the agricultural centre; the fourth the educational centre.

There is no State now advancing so rapidly in growth of population and annual increase in money invested in legitimate enterprise, in short, in material prosperity. It is conceded that her furnaces can make a ton of iron cheaper than it can be done anywhere in the world, and this in a nutshell is the philosophy of the situation. She has not yet reached her flood-tide of prosperity, and will not for years to come. Hence, those who locate there now but anticipate better times.

Statistics show that the collapse of a few local booms has not in the least abated the golden flood of capital that is sweeping into the State from all directions, especially from North and East.

Yours sincerely,

A. L. MONROE, M.D.

## EDITORIAL.

## RHUS TOXICODENDRON AGAIN.

SINCE Dr. John Aulde, of Philadelphia, announced his great discovery (?) that rhus toxicodendron was an exceedingly valuable remedy in certain cases of rheumatism, numerous other allopathic physicians have given testimony of its value. These few remarks are penned in order to direct attention to the most recent of these papers; and we might add a most interesting paper too. We refer to a short article bearing the unassuming title "Rhus Toxicodendron," by Dr. Charles R. Carpenter, of Leavenworth, Kansas, and published in the *Therapeutic Gazette*, for February 15, 1890. Thus does he open his discourse:

"History repeats itself, as well in the medical profession, it seems, as elsewhere.

"The investigations of Dr. Aulde concerning the action of rhus toxicodendron are an illustration of this fact. Prosecuted as they were independently of any previous investigations, he arrives at exactly the same conclusions that were enunciated by another investigator many years ago.

"I stumbled upon this fact as accidentally as did Dr. Aulde upon the clue which led him to investigate the drug in question."

When we read the above quoted opening sentences we thought that the author thereof was inclined to be ironical; in fact, its words were so innocently refreshing that we almost felt that some poor homœopath had found a hearing in the pages of the *Gazette*, and was about to have a little fun at Dr. Aulde's expense; but on glancing at the ending of the paper we observed there a foot-note by the whilom editor of our esteemed contemporary, showing that he took all this testimony of the value of rhus toxicodendron as a remedy in rheumatic affections very seriously, and what is more, he did not seem to be pleased with it. We then knew that Dr. Carpenter was in earnest. Yes, he was an earnest seeker after truth. Let us resume our quotations from his paper:

"Upon reading the article by Dr. Aulde in the October number of the *Therapeutic Gazette* I was much impressed with it, and resolved to give the drug a trial. Not having the facilities for manu-

facturing tinctures according to his directions from the fresh plant, and it being rather late in the season to gather the plant anyhow, it became a problem to secure a suitable preparation of the drug. It occurred to me, however, that I had heard of rhus being used by homœopathists for certain inflammatory conditions of the skin simulating the well-known rhus poisoning. Following up this thought, I remembered also to have heard that the basis of the homœopathic therapy was a system of tinctures, which, it was claimed, were very concentrated.

"Going to my druggist, I asked him if he had any of these tinctures? He replied in the affirmative. I ascertained, also, that he had the particular tincture for which I was looking."

The worthy author then proceeds to narrate how he made a dilution from this tincture, and how he cured, in an incredibly short space of time, three cases of rheumatic affection. Here, then, was a great therapeutic discovery. Here was an opportunity to teach the homœopaths something new concerning the use of rhus. So when Dr. Carpenter encountered the leading homœopathic physician of Leavenworth, who, he says, "is a very intelligent gentleman, and a worthy man in every respect," the following conversation took place:

" 'Doctor,' I asked, 'in what connection do you and the members of your school use rhus toxicodendron?'"

" 'We use it,' he replied, without any hesitation, 'in certain forms of rheumatism.'"

" 'What forms,' I asked,—'inflammatory?'"

" 'No,' said he, 'in the chronic forms, in muscular rheumatism, and in different forms of neuralgia. We use it also in the soreness of muscles, due to over-exercise.'"

"Not a word was said about skin diseases, and in fact, so taken back was I that I neglected to ask about that phase of its therapy."

"I remarked that I had recently read an article upon the use of rhus in rheumatic affections and had been trying it."

" 'Oh, yes,' he remarked with a bland smile; 'it is an excellent remedy in those conditions. We have used it for a long time—some seventy-five or eighty years, I think.'"

Thus endeth the paper. To say that we were interested is making a mild statement. To say that we were amused at the author's innocence is likewise.

But how did the whilom editor of the *Therapeutic Gazette* look upon Dr. Carpenter's addition to medical literature? He didn't like it. He proceeded forthwith to make some remarks which might destroy the effects of such heretical teaching. He advances an argu-

ment (?) utterly without point, which, if it proves anything, proves that as the therapeutics of the old school are unreliable so far as the treatment of rheumatism is concerned, the homœopathic therapeutics of that disease must be the same.

He then tells how he investigated the virtues of *rhus toxicodendron*. He purchased some of the tincture from a leading homœopathic pharmacy. He then proceeded to give it indiscriminately in a "large number of cases, subacute, chronic and acute rheumatism." He tried it in all sorts of doses, and found that it gave no definite good results. In other words, he gave it indiscriminately, and in some cases good results were obtained. Now this is just what we, as homœopaths, claim for *rhus*—that it will cure but a limited number of cases of rheumatism. Dr. Wood, prescribing it indiscriminately, only obtained good results in those cases in which it was the proper remedy; we, by our law, are enabled, *a priori*, to select those cases which *rhus* will cure, and leave the remaining cases (in which *rhus* given indiscriminately will be valueless) to the beneficent action of other remedies equally potent for good when indicated.

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#### A MEDICAL COLLEGE CONFERENCE.

THE medical colleges and schools of Maryland held a meeting on February 7th, and as a result of their deliberations issued an appeal to the medical colleges of the United States, asking them to send delegates to the approaching convention of the American Medical Association at Nashville, Tenn., with a view of effecting a reform in the methods of medical institutions in this country. "The following subjects are considered as most likely to come up for discussion : 1. Three years' course of six months' sessions. 2. Graded curriculum. 3. Written or oral examinations. 4. Preliminary education in English. 5. Laboratory instructions in chemistry, histology and pathology."

Representatives of homœopathic colleges were not invited to be present at the proposed conference; but then that was not necessary, as all the homœopathic colleges in the United States require of their students three years' attendance on lectures, each course being of six months duration at least; they also give practical instructions in laboratory and class-room chemistry, histology, obstetrics, surgery, anatomy, etc.

There is only one way for the American Medical Association to aid in securing the proposed reform, and that is by amending its by-laws so as to provide that no physician shall be eligible to membership who is a graduate of a medical college that does not make the above-named requirements of its graduates. This is what the American Institute of Homœopathy did, and the American Medical Association should follow its worthy example.

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#### EXAMINATIONS FOR APPOINTMENT IN THE MEDICAL CORPS OF THE UNITED STATES ARMY.

WE take pleasure in making the following announcement, though we have not been requested to do so :

"An Army Medical Board will be in session in New York City, N. Y., from May 1 to May 31, 1890, for the examination of candidates for appointment in the Medical Corps of the United States army to fill existing vacancies.

"Persons desiring to present themselves for examination by the board will make application for the necessary invitation to the Secretary of War, before April 1, 1890, stating the place of birth, place and State of residence, and enclosing certificates based on personal knowledge from at least two physicians of repute, as to professional standing, American citizenship, character and moral habits ; also statement of service in hospital from authorities thereof is desirable. The candidate must be between twenty-one and twenty-eight years of age and a graduate from a regular medical college, as evidence of which his diploma must be submitted to the board."

It is a well-known fact that homœopathic physicians are not eligible to appointments in the army and navy service. Whenever this subject has been brought before the proper authorities we are told that such is not the case ; that no homœopath has been refused, etc. We therefore publish the above notice, and would call upon some of our representative young men to make application to the Secretary of War for the necessary invitation to the examination, and that in proof of his graduation from a regular medical college he exhibit his diploma from his homœopathic alma mater. If he is refused the invitation requested, then let the reasons for that refusal be made known, and action taken on the same at the first annual session of the American Institute succeeding.



## GLEANINGS.

## GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.

ON THE FUNCTION OF THE STOMACH IN DISEASES OF THE HEART.—E. Huefler (*Munch. Med. Wochenschrift*, 1889, xxxvi., No. 33,) says that of the various affections in which the stomach is secondarily disordered, tuberculosis is the only one in which sufficiently careful and extended investigations have been carried on. A second group of disorders, in which Ewald says there is a chronic catarrh, is that of the diseases of the heart. As it is such a common occurrence for patients with cardiac affections to complain chiefly, or even exclusively, of gastric symptoms, the author has endeavored, in a series of cases, to examine the actual condition of the gastric function as far as the state of the patients permitted. With this end in view, he administered the meal proposed by Leube usually at about 9 o'clock, and on an empty stomach. The meal consisted of eight ounces of roasted and chopped beef, one ounce of bread, and not more than one glass of water.

In two hours the effort was made to press out some of the contents of the stomach through the sound, and without the addition of water. This was always successful. The remainder was left to undergo digestion, and a sample of it was removed after this had been going on six hours; the stomach being after this entirely washed out. Where the condition of the patient permitted it, these examinations were frequently repeated. In other cases only the two examinations were made in all, and sometimes these conducted on different days.

The material which had been removed was filtered, and its reaction tested with litmus paper. The presence of hydrochloric acid was then tested with phloroglucin-vanillin, and that of lactic acid by Uffelmann's test. It was not found necessary to determine the degree of acidity. Methyl-violet was also employed in the examination for hydrochloric acid, but the author considers it by no means so reliable as Gunzburg's reagent. Where the quantity of the gastric juice obtained permitted it, the digestive strength was tested in a warming-oven at 98.6° F., and sometimes the examination for syntonin and propeptone was carried out. The author gives the details of the individual cases—ten in all—and remarks on the fact that, except in one instance, free hydrochloric acid was never found in the gastric contents in heart disease. In this case there was free acid present after six hours; at a time when hydrochloric acid should have disappeared from the normal stomach. The case was therefore one of hyperacidity, which the alkalinizing action of the heart disease had not been able to neutralize.

The author believes that, as a result of passive congestion in the circulation in the stomach, either there is an effusion of alkaline serum mixing with the acid, or else the simple retardation of the blood-current is answerable for the diminution of hydrochloric acid. The disturbance of the secretion is evidently very easily affected, since the majority of the patients examined had no subjective symptoms of gastric disorder. Mild cases of heart disease do not necessarily produce a gastric catarrh, but simply a diminished secretion; and the lack of fine divisions of the food, which is the result of this, is overcome by the powerful muscular action of the stomach. It is advisable, therefore, to administer hydrochloric acid to patients with heart disease in order to favor this minute division of the food, and to relieve the gastric muscles of the necessity of pressing large portions through the pylorus. In this way the development of an actual catarrh may, perhaps, be prevented.—*Amer. Jour. Med. Sci.*, December, 1889.

GUNPOWDER STAINS.—The *Peoria Monthly* claims that the stains produced by gunpowder may be removed by first painting the skin with a solution of biniodide of ammonium in an equal part of distilled water, then with dilute hydrochloric acid.

**THE INHERITANCE OF TUBERCULOSIS.**—To determine if the children of tuberculous parents inherit the disease, or simply the predisposition, Dr. Sanchez-Toledo, *Lyon Medical*, October 20, 1889,—made the following experiments: In the first series, on fifteen pregnant Guinea-pigs, 1 c.c. of the tubercular virus of Koch was injected in the jugular vein. At the end of twelve or fifteen days the animals died with their organs filled with bacilli. Thirty-five fetuses were removed in whose organs no traces of the germs were found. Cultures of the blood, liver and spleen remained completely negative. Thirty-five Guinea-pigs inoculated with the foetal organs remained in good health, and when killed no trace of tubercular disease was found.

In another series, eleven pregnant Guinea-pigs were inoculated by injections into the pleura, and their seventeen fetuses gave the same negative results. Finally, in a third series, nine pregnant Guinea-pigs were inoculated under the skin, with cultures or the fresh expectorations from phthisical patients, with the same results as above. The author deduces from these experiments that the bacillus tuberculosis rarely enters the placenta, and that in consequence direct hereditation of tuberculosis is very exceptional.

As to the rarity of the transmission compared with anthrax, chicken cholera, etc., he believes it is because the microbes of these diseases lie in the blood, whilst the habitat of Koch's bacteria is the lymphatic system.—*Medical News*.

**THE CURABILITY OF PHTHISIS.**—From a clinical and pathological study of the subject, Harris thinks that we are warranted in recognizing three groups of cases as bearing upon the question of the curability of phthisis. 1. Cases where the only remains of tuberculosis are fibrous tissue or completely calcified caseous foci. These are the only cases which can be regarded as perfectly healed. 2. Cases where there remains a caseous mass, which is not at all or only partially calcified. Such cases are probably not uncommonly regarded by the physician as cases of healed phthisis, but by the pathologist they cannot be so considered. They are cases which may give rise to local or general tuberculosis. Probably many cases of phthisis, at one period of their history, come under this class, such cases being characterized by a history of a previous illness, due to a tubercular lesion in the lung, from which the patient has recovered, and remained free from signs of disease for a longer or a shorter period. 3. Cases which are characterized pathologically by the formation of much fibrous tissue, but where microscopically all the elements of tubercle are to be found at the periphery of the lesion. Clinically these cases present the usual features of a very chronic phthisis, but in some cases the lung change is so limited and so very slow in progress that the general health is very little affected, and the physical signs may be very indefinite and not at all conclusive as to the existence of phthisis. Not uncommonly the physical signs are considered to indicate that the tubercular process is quiescent, which is not the case. It is probable that the majority of cases of phthisis which have at one time presented distinct symptoms and physical signs, and at a later period have become apparently quiescent, really belong to this class. They are cases which are very misleading to the physician, since they cannot be regarded as perfectly cured, but only quiescent for a period. If we had an opportunity of examining such a lesion microscopically, at a time when from clinical observation we should infer they were quiescent, we should find that there were signs of activity at the periphery of the focus.—*British Medical Journal*, December 21, 1889.

**PHTHISIS HAS A LOW RATE OF MORTALITY.**—That there are conditions under which human beings recover from consumption seems to be well proved by many observers. Loomis is recently reported to have said that in no less than 60 per cent. of the patients dying at Bellevue Hospital, there were old tubercular changes in the lungs, the disease having been recovered from. If 13 or 15 per cent. of all deaths are from consumption, and 60 per cent. of those who die of other diseases have had consumption, or at least "tubercular change in the lungs, from which they have recovered," it would appear that the specific cause gains a lodgment in 73 per cent. of all persons, and proves fatal in only about 13 or 15 per cent. of all persons. Musser, speaking of tubercular phthisis, said: "In the autopsies made at the Philadelphia Hospital it is surprising to see the almost universal presence of this disease, in a more or less active state, in patients dying from other affections, such as Bright's disease or carcinoma"—*Journal of the American Med. Association*, January 18, 1890.

**A NEW METHOD OF ADMINISTERING COD-LIVER OIL.**—Gubb, of London, is authority for the statement that the disagreeable taste of cod-liver oil may be made to entirely disappear by mixing the oil with extract of malt that has been prepared in vacuo. Attention is directed in this connection to a remarkable phenomenon: The aqueous extract of malt placed in contact with cod-liver oil dissolves it. This solution is perfectly clear and transparent, and shows no fat globules under the microscope. In this manner, strange as it may seem, a true solution is produced. To displace the oil it is only necessary to place a drop of water on the surface, when immediately small drops of oil will appear. In this manner the oil which was in solution becomes an emulsion, but this emulsion is more perfect than that of butter in milk. Only extracts of malt which are rich in diastase possess this property. Invalids, and especially children, enjoy the emulsion, and far from disturbing digestion as the raw oil too often does, the malt improves it.—*Journ. of the Amer. Med. Association*, January 11, 1890.

**RESORCIN IN ASTHMA.**—Andeer reports the case of a lady who suffered for two days with cramps, excessive gastric flatulence, pressure over the diaphragm, dyspnoea with pains radiating both upwards and downwards; took one gramme of resorcin dissolved in water, with great relief. In another severe attack which occurred some time after the one just mentioned, another similar dose brought on a refreshing sleep, since which she has had no attack of asthma.

In another patient, an emphysematous workman of middle age, resorcin gave more relief to the asthma than any remedy he had hitherto tried.

A gentleman of middle age, suffering from asthma with disease of the nasal cavities, was advised to have his nose operated upon. But, being averse to such a procedure, he took resorcin in such a large dose as to cause acute poisoning; but there followed a long, refreshing sleep, from which he awoke entirely free from his asthma. He has remained well since then.—*Allgem. Med. Centr. Zeitung*, 98, 1889.

**AN EFFECT OF MORPHIA EATING.**—In a clinical lecture on morphia eating, Dr. William Pepper said that it was his experience, that when morphia has been given for any length of time for the relief of pain, there occurs a mimicry of the disease on the gradual withdrawal of the drug; a simulation of the original aches and pains which imitate the real complaint so cunningly that it is often difficult to decide their true source.—*Canada Lancet*, January, 1890.

**THE INFLUENCE OF OXYGEN UPON THE NITROGENOUS SUBSTANCES OF THE URINE.**—Dr. Krafft (*Revue Médicale de la Suisse Romande*), has been making researches to throw some light upon the problem of combustion in the body. His experiments bore upon the relation of oxygen to urea, uric acid, and the total nitrogen of the urine. He was searching to find out whether oxygen affected these bodies qualitatively or quantitatively; whether by oxidation of uric acid it was able to convert that substance into urea, and whether uric acid is an intermediate waste product, or whether it has, so to speak, an independent origin. The experiments were conducted with great care and attention to details, as regards both the chemical processes employed and the general conditions. The subject was the author himself; he having satisfied himself that he was in health and that the urine was normal in every respect. The diet, mental and physical work, and sleep, were practically the same during the period of sixteen days over which the experiments extended. The same regimen was adopted for three days before. During the first period of eight days without oxygen inhalations the amount of urine, urea, uric acid, and total nitrogen of the urine were carefully noted, and the body-weight taken three times daily. This was done also, during the second period of eight days, upon each of which rather more than thirty-five litres of pure oxygen were inhaled. The following are the results obtained. *Urine*: The difference between the total amount passed in each of the two periods was only 10 c. c., and the average difference for the days was 2 c. c. This goes to prove that the diet was practically the same throughout. *Urea*: Taking the average daily amount of each period, the difference was only about ten grains in favor of the second. This proves nothing, as the amount of urea excreted varies considerably in natural conditions. *Uric acid*: The difference here was less than one grain in favor of the period without oxygen. *Total nitrogen*: The difference here is more marked, being about thirty-five grains in favor of the second period—that with oxygen. But this can scarcely be considered to be of importance. Estimating the uric acid and urea as nitrogen, there was found during the period with oxygen an average diminution in uric acid of about

one-fifth grain, and an average increase in urea of about  $4\frac{1}{2}$  grains. Taking into consideration, then, the quantity of oxygen absorbed daily (thirty-five litres), it appears to be exceedingly doubtful whether oxygen inhaled has any influence upon the formation of uric acid. The body-weight was lessened about ten ounces. This is contrary to the effect usually observed after inhalation of oxygen; but the diet in this case being fixed, an improved appetite had no influence. The conclusions drawn from these observations are: That inhalation of oxygen neither increases the urea nor diminishes the uric acid; that there is no oxidation of uric acid, and that there is no relation in that respect between it and urea, and that the increase in the total amount of nitrogen eliminated during the oxygen period is not large enough to warrant the drawing of any conclusion from it.—*The Manchester Medical Chronicle*, January, 1890.

**OXYGEN IN THE TREATMENT OF LEUKÆMIA AND GRAVE ANÆMIAS.**—Drs. Da Costa and Hershberg report results in the treatment of two cases of splenic leukæmia, and two of chlorosis, with inhalations of oxygen. The changes in the blood in the cases observed were followed out in every detail, and the conclusions rest, therefore not on impressions, but on actual minute inspection of the blood-corpuscles; though positive conclusions cannot be drawn from so few cases. The improvement in all was so rapid that the method claims a fair trial in every case of grave anæmia. The first patient was a boy aged thirteen, with general debility, and enlarged spleen, and blood-corpuscles numbering 2,350,000 red to 320,000 white, per cubic millimetre. Basham's mixture, ergot, trinitine, galvanism and other measures were without effect, the patient growing rapidly worse. On inhaling daily from 20 to 30 litres of oxygen, immediate improvement commenced and continued. In two months the patient resumed work, and at the end of the third month the red corpuscles numbered 4,450,000 and the white about normal.

Case II. A man of thirty-five years, suffering from polyuria with an unquestionable thirst leading to excessive alcoholism. This patient had undoubtedly suffered from leukæmia for years. The regulation treatment, as usual, proved a complete failure. The patient was exceedingly weak, with œdematous feet and legs; dyspnoea on slightest exertion, profuse watery diarrhœa; temperature  $102.3^{\circ}$ ; depressed in spirits, etc. Great emaciation with an enormous spleen extending two inches beyond the umbilicus. The blood contained 1,440,000 red corpuscles and 1,120,000 leucocytes, a proportion of as 1:1 $\frac{1}{4}$ . The leucocytes were of various sizes and shapes, and the red corpuscles were pale in color, and were not formed in rouleaux, but were widely separated. After two days' inhalations of oxygen, 10 litres, three times a day, the character of the blood was entirely changed; observed on the glass slide, the large and misshapen leucocytes had entirely disappeared, the red corpuscles formed rapidly in rouleaux. At the end of the week œdema had almost disappeared, the temperature had steadily fallen, until it reached normal; the appetite was good. The number of white corpuscles had diminished nearly one-half, while the red had gained a million. With the exception of a short period, during which, from indiscretions of the patient, the white corpuscles increased and the red diminished, slightly, the patient steadily improved in every respect, the spleen being markedly reduced in size. During the course of treatment the oxygen was increased to 100 litres a day in two sittings. No other drugs were given other than a mild hypnotic at night and, for a few days, Basham's mixture. In two cases of chlorosis, oxygen was used as an adjunct to iron. The results, while excellent, were not as good as in the cases of leukæmia.—*Amer. Journ. Med Sci.*, November, 1889.

**ORIGIN OF THE VESICULAR RESPIRATORY MURMUR.**—Dehio (*Deutsche Med. Wochenschr.*, No. 29, 595, 1889), claims that several clinical facts oppose the explanation given by Bous and Penzoldt of the origin of the vesicular respiratory murmur, according to which it is to be considered as a bronchial respiration, a stenosis-sound produced in the larynx and modified by passing through the pulmonary parenchyma containing air. Among these facts is the diminution of the vesicular murmur in cases of laryngeal stenosis, though there is a very loud sound of stenosis produced in the larynx.

The diminution of the murmur in dry pleurisy, owing to the limitation of motion of the affected side as a result of pain, and the harsh puerile breathing of children, though without any increase of bronchial breathing over the larynx and trachea, are both opposed to the theory of Penzoldt. If heavy weights are laid on one side of the thorax of a man in a reclining position, until the respiratory movements are nearly

or entirely prevented, the vesicular murmur is made decidedly weaker than on the other side, which could hardly be the case were this simply a transmitted sound.

Dehio holds that vesicular respiration is not a sound transmitted from the larynx, but is produced within the lungs, and he believes that the following experiment demonstrates this: A lung, dried by injections of glycerin and consequently elastic, is distended by air blown from bellows through the bronchus; but at the same time a loose plug of cotton placed in the bronchus does away with any bronchial murmur which might otherwise arise. The ear placed over the lung will now hear no bronchial murmur, but a loud and unmistakable vesicular murmur. We must, therefore, return to the former view, that the vesicular sound is produced within the lung.

Regarding the question as to how this is brought about, there are two possibilities:

1. That the sound is due to vibrations of the air passing through the lungs, these vibrations being seated in the finest bronchioles or in the alveoli; since were they produced in the large bronchi, a bronchial murmur would be the result.

2. The view of Gerhardt, is that the vesicular sound is the result of the tension on the pulmonary parenchyma, especially of the alveolar septa, occurring at each inspiration. Dehio believes the following experiment proves that Gerhardt's explanation is not correct, and that the theory of the vibrations of the current of air is the one to be adopted. The glycerin-dried lung is moderately distended, the cotton placed in the bronchus, as before, and for the same purpose, and the bronchus then closed entirely air-tight.

If now gentle compression be made on any part of the lung and then the pressure be relaxed, a distinct vesicular murmur can be heard on auscultation. This must be due to the motion of the air from one part of the parenchyma to another under the influence of the pressure, and the return of the same to the compressed alveoli after the pressure is removed.

With the moderate distension of the lung, there can be no possibility of tension on the parenchyma such as Gerhardt claims. Since we know, now, that sonorous vibrations of air in the bronchial tubes can only be produced where there is a sudden alteration of calibre, the sound must be developed at the point at which the finest bronchi normally undergo a sudden narrowing, i.e., at their last bifurcation, and at the point of entrance of the bronchi into the infundibula. The combination of these numerous stenosis-murmurs is the origin of that acoustic phenomena which we designate the vesicular respiratory murmur.

In the living person, however, there is a combination of this with the bronchial sound transmitted from the trachea and bronchi, and altered by passing through lung tissue.

The vesicular murmur heard on the living chest is, therefore, somewhat modified, and is not always so distinct as that heard over the prepared lung.—*Amer. Journ. Med. Sci.*

**EFFECTS OF PROLONGED CHLOROFORM ANÆSTHESIA.**—Some observations made about two years ago by Dr. Ungar pointed to fatty degeneration of the heart and liver as the cause of death after repeated prolonged administration of chloroform. Further experiments on dogs have recently been made by Dr. Strassman, which appear to confirm this view. Dr. Strassman found that the first organ to be affected was the liver, then the heart, and after that other viscera. The nature of the morbid change was not a fatty degeneration, but fatty infiltration. The actual cause of death in fatal cases appeared to be the cardiac affection, as in all such a very marked degree of change was found in the heart. In non-fatal cases the morbid change was found to have disappeared in a few weeks' time. When morphine was given previous to the chloroform, less of the latter was required, and, consequently, the changes produced were not so considerable as when the ordinary amount was given. Animals suffering from hunger, loss of blood, etc., were especially predisposed to the morbid changes due to chloroform.—*The Lancet.*

**TO CURE A BLACK EYE.**—There is nothing to compare with the tincture or a strong infusion of capsicum annuum mixed with an equal bulk of mucilage of gum Arabic, and with the addition of a few drops of glycerin. This should be painted all over the surface with a camel's-hair pencil and allowed to dry on, a second or third coating being applied as soon as the first is dry. If done as soon as the injury is inflicted, the treatment will invariably prevent the blackening of the

bruised tissue. The same remedy has no equal in rheumatic stiff neck.—*St. Louis Polyclinic.*

**INHALATIONS OF COLD AIR IN HÆMOPTYSIS.**—Dr. P. de Tullio, assistant to Prof. Cantani, in the University Clinique, at Naples, has lately suggested a method of applying cold air directly to the interior of the lungs in cases of pulmonary hæmorrhage. The apparatus consists of a metal box through which run several tubes, which communicate with an outer larger tube leading to a mouthpiece, which the patient holds between his lips. The box is filled with ice, or with a mixture of snow and salt, so as to cover the tubes. Air is then pumped with a suitable bellows into the tubes, and in its passage through the box containing the refrigerant substance it becomes cooled down to 0° centigrade. This is ascertained by means of a thermometer introduced into the tube at some distance beyond the box, through an aperture which can be closed with a cork. Dr. de Tullio reports three cases in which severe hæmoptysis was arrested by this plan, when drugs, ice to the chest, and the other usual measures had failed. It does not, of course, cure the condition on which the bleeding depends, but it is an effectual remedy for the symptom.—*Medical Recorder.*

**THE PSEUDO-PARAPLEGIA OF RACHITIS.**—It often happens that children on reaching the age of two, four or even five years, are found unable to walk or even sit up; the amount of disability varying with the severity of the case. Even when it does succeed in walking, its gait is interfered with by frequent falls. It is a common mistake to diagnose such cases as infantile paralysis, or paralysis from reflex causes, certainly a grave error. Dr. H. W. Berg in laying down rules for the recognition of such cases, says that the patient is possessed of the typical rachitic body. Open fontanelles, the rachitic rosary, and the enlargements at the ends of the long bones are all present. A most important diagnostic point is that the bony prominences at the insertion of muscles are felt to be exceedingly tender. This excessive tenderness at the points of muscular insertion is due to a chronic periostitis at joint ends. When the little one is in the recumbent position, it will be found that he has good control over all the movements of the joints. The electrical reactions of all the muscles are normal. This differentiates it from poliomyelitis anterior. From post-diphtheritic paralysis, it may be separated by the history of the case. The prognosis in cases of rachitic pseudo-paraplegia is favorable, all cases eventually ending in recovery of motor power.—*Medical Record*, November 16, 1889.

**GASTRIC TABETIC CRISES**—(1) The crises of tabes may become so severe, that we think of biliary or nephritic colic, or of poisoning. In other cases symptoms of collapse prevail, so that the cyanotic, nearly unconscious, prostrate patient may be considered to suffer from cholera or uræmia. Again it may set in as a comatose stupor, apparently pointing to cerebral affections. (2) Sometimes only the pains are present, without any vomiting, or (3) there may be no pain, but only vomiting. (4) In rare cases the crises may appear daily, but are of shorter duration. (5) More frequently they last unusually long, a month or more, and the intervals become steadily shorter; aggravation and amelioration may alternate. Buzzard reports a case where the pains, inappetency and vomiting lasted nine months. Sometimes gastric crises alternate with laryngeal crises; in the latter case there is an unceasing dry cough, similar to whooping cough, spastic laryngeal attacks with tendency to suffocation, a deep bass voice, etc.; it often happens that several years may elapse before the disease is fully recognized as tabes dorsalis.—*Gaz. Méd. de Paris.*

**MASTITIS IN MALES.**—Mastitis in young males during puberty is not very rare. Its symptoms are painful stitches in the mamme, which may be so sensitive to pressure that even the wearing of a shirt becomes unbearable. The inflamed gland may swell up to the size of a small orange, the nipple protrudes and the swelling of the mamma can be easily felt. The affection is mostly unilateral. Suppuration is exceptional; though the inflammatory symptoms disappear, the enlargement may become permanent. Traumatism is a frequent cause of the trouble; some believe that it results from onanism, but this is doubted by others. It is an accidental affection of puberty that usually passes away in a few weeks. Mastitis of adults may be acute or chronic, or may accompany phthisis. In acute cases the symptoms are the same as in young people, but the axillary glands often swell up and suppuration may set in. It also lasts longer than in young people and becomes more rare with advancing years. It is generally due to traumatism and pressure. The chronic form

always leaves behind some glandular enlargement, and must be differentiated from gynæiomastia, when more or less of the feminine habitus prevails and the sexual organs show an atrophic state. The mastitis of phthisical patients is mostly unilateral, without any inflammatory symptoms, with spontaneous pains and some sensitiveness to pressure, lasts several months and passes away without suppuration.—*Gaz. Méd. de Paris*, 23, 1889.

**HEART DISEASE IN PREGNANCY.**—The influence of pregnancy on heart disease—especially on mitral disease—has been very differently interpreted, and the duties of an honest adviser in cardiac cases in which he is consulted as to the permission or advisability of marriage are by no means clearly laid down. Peter, Landouzy, and others were quite firmly opposed to marriage in the case of a woman with distinct mitral disease, more especially in stenosis. M. Porak reports six deaths out of thirteen persons who became pregnant in this condition. Jaccoud would be inclined to allow marriage in such cases of mitral disease as have had no secondary accidents due to cardiac disease, and to forbid it in others. A case which M. Budin publishes shows many of the bearings of the question. Madame T., a Polish woman, aged twenty-three, had reached the eighth month of her first pregnancy, when she was brought into the Charité in a state of serious cardiac failure. Her sister, who was a medical student, could give good information as to the past history. Her father died of heart disease, but she had not had any rheumatism, chorea, or serious illness; there had been no oedema, no hæmoptysis. That she had had some heart disease fifteen months ago was known, but its nature and origin were uncertain. In the fifth month of her pregnancy she had had hæmoptysis, and her medical attendant had examined the lungs, but not the heart. Dr. Budin was called in about a week before the term, and found signs of mitral stenosis (thrill, presystolic murmur, and reduplication of the second sound) accompanying extreme dyspnoea, oedema and a very weak pulse. He proposed that she should be taken to the hospital and premature labor induced. This suggestion the family at first declined, but ten days later, as matters grew worse, she was taken to the Charité in a state of advanced cyanosis. The pulse was just perceptible, thready, but not intermittent. Four hours after her admission M. Budin decided to induce labor, and a large uterine sound was introduced. A little chloroform which was used made the pulse imperceptible, but champagne, oxygen and coffee supplied a little stimulus. Pains began in about twelve hours, and after a very critical time delivery was completed by forceps, the oedema of the vulva proving a serious obstacle. Considerable hæmorrhage and great exhaustion followed, but next day there was improvement, and it was noticed that the presystolic murmur was now replaced by a long diastolic one. She died four days after her confinement from cardiac failure. At the necropsy there was found considerable stenosis of the mitral orifice, with valves that had grown together at their bases, but were nearly competent to prevent regurgitation. There was also some tricuspid incompetence. No bacteria were found there by the staining methods of Weigert, Kuhne, and Gram. The walls were pale and the muscular tissue showed many broken fibres, but there was no fatty degeneration. The liver and other viscera were much congested. The most interesting points are: (1) the reason of the union of the bases of the mitral valves, probably congenital and slowly increasing, and (2) the importance of the hæmoptysis at the fifth month, which if it had been rightly interpreted might have led to earlier obstetrical intervention.

**PATHOLOGY OF CARDIAC FAILURE.**—The literature of the pathology of cardiac failure has been enriched by a valuable paper read by Dr. F. W. Mott in the Pathology Section of the meeting of the British Medical Association. In considering this important subject, Dr. Mott insisted that the whole cardio-vascular system and its contained blood must be taken into account, as in all cases of circulatory failure there was some alteration in its nutrition. In myo-carditis, fatty degeneration, and other conditions, there was usually coronary obstruction. Dr. Mott laid special stress on the importance of carefully examining the coronary arteries, not only at their openings into the coronary sinuses, but also for some distance from the mouth, as he frequently found them constricted at as much as one inch from this point. Of fifty cases examined there was, with one exception, organic disease of the myocardium. The degeneration associated with partial obstruction was not usually a fatty metamorphosis, but often was merely part of a widespread degenerative process, associated with chronic inflammation affecting the cardio-vascular system, particularly in the heart and kidneys. There had been a syphilitic history in most of the

cases of complete obstruction of a principal branch of one of the main trunks, with partial occlusion of the other, and of five such cases four had died suddenly from syncope due to fatty degeneration of the myocardium. In discussing the conditions met with in chronic alcoholism in which there was no affection of the coronary arteries, but in which fatty degeneration had been followed by sudden and fatal syncope, Dr. Mott pointed out how in cases of fatty degeneration the arrangement of the muscles led to imperfect action of the valves—the muscoli papillares, in which the process is best seen, being the continuation of the figure-of-8 bundles of muscular fibres in the walls of the cavities of the heart.

This explanation could be readily adapted to Prof. McWilliam's theory of "delirium cordis." In no case should a conclusion as to fatty change be arrived at without a microscopical examination; and Dr. Mott recommended that osmic acid, or Pal's modification of Weigert's method, should always be employed to determine the amount and distribution of fatty degeneration of the myocardium.—*The Practitioner*, January, 1890.

**NEW TEST FOR ALBUMEN.**—G. Roch recommends the application of a reagent, which he calls sulpho-salicylic acid, in testing for albumen. It is produced by the action of sulphuric acid upon salicylic acid. If a few crystals of it are shaken up with a few ccm. of clear urine, it is possible to detect the presence of 0.5 mgr. of albumen in 10 ccm. of urine.—*Monatsh. für prakt. Dermatol.*, Bd., 10, No. 2.

**PUPILLARY CHANGES WITH NEURASTHENIC SYMPTOMS.**—Pelizæus found among 320 patients with symptoms of cerebral neurasthenia, 11 cases with inequality of the pupil, without any other symptom of organic disease. The unilateral dilatation of the pupils occurred always on the same side in some of the cases, while in others it changed from one eye to the other. The symptom was observed mostly when the patient was constitutionally "run down," and disappeared temporarily when he felt more like himself again.—*Allgem. Med. Centr. Zeitung*, 1, 1890.

**SCLEROSIS OF THE PANCREAS AND DIABETES.**—Pilliet describes three typical forms of diabetes. 1. Those of nervous origin, such as occur during the course of locomotor ataxia and in sclerosis of the lower part of the fourth ventricle. 2. Cases based on heredity or arising from constitutional causes, accompanied by considerable development of fat. 3. Diabetes in connection with abdominal changes, especially with atrophy or induration of the pancreas. In the nervous form the diabetes sets in suddenly, with great hunger and thirst and rapid emaciation; the patients lose their teeth, hair and all physical and moral power; the skin becomes dry and pale, and patient may die in less than a year. 2. In constitutional diabetes the auto-intoxication leads rapidly to dyspnoea and coma or broncho-pneumonia, and tuberculosis hastens the fatal issue. The clinical symptoms of atrophy or induration of the pancreas, which accompany these cases, are uncertain and changeable; vomiting of fatty masses, feces contain fat and undigested food; the stomach fails to tolerate any food; rapid emaciation; skin pale and dry, as in affections of the plexus-solaris. Sometimes one meets sclerotic changes around the veins, or atrophy, or induration in the form of small calculi or fatty degeneration.—*Allgem. Med. Centr. Zeitung*, 2, 1890.

**COMPLICATIONS AND SEQUELÆ OF INFLUENZA.**—Holz, of Berlin, reports a number of cases of influenza, with complications and sequelæ: A man of thirty-six years suffered, during an attack of influenza from most obstinate nose-bleed, which endangered his life, and brought on a long convalescence. Two sisters, six and three years old respectively, were attacked on the second day of their disease by choleraic symptoms, with convulsions and loss of consciousness, lasting 24 hours. Both recovered. A man of thirty-six years had with his grippe a most severe and obstinate headache, which soon changed to a prosopalgia of the first and second branch of the trigeminus with swelling of the upper lid. He acknowledged syphilis, and was therefore put on kali iod., which finally cured him. A gentleman of the same age caught the grippe, but, though very weak, attended to his business, and a relapse followed, during which he had fits of suffocation, with difficulty of deglutition, caused by an inflammatory swelling of the right lobe of the thyroid gland, and the swelling remained after the grippe left him. During the development of the tumor he complained of pains in the back, great prostration and copious sweating. The spleen appeared normal; there was also a slight prominence of the globes of the eyes, so that one thought involuntarily of exophthalmic goitre, but Græfe's symptom was absent, and pulse and temperature corresponded.



Ferrand of Paris observed a special phenomenon, preceding the pulmonary complications of the grippe, a diminution of the respiratory murmur, with aggravated resonance and increase of vocal vibrations on the whole or part of a lung. He considers it a kind of atelectasis of the lung, which passes into a pneumonia. He saw it in a young girl who recovered, and in an old lady who died.—*Semaine Méd.* 3, 1890.

**INFLUENZA AND OTITIS MEDIA.**—Dr. Lowenberg, of Paris, observed during the epidemic of la grippe a considerable increase of otitis media, with its intense pains (ceasing as soon as perforation took place), with purulent discharge and total deafness; there were only slight catarrhal troubles in the Eustachian tube. The whole trouble ran a rapid and favorable course, the otitis disappearing with the influenza, and the hearing being fully re-established. Dr. Krakauer, the chief otologist of Berlin, also met many cases of otitis in his city during the prevalence of la grippe.—*Bull. Med.* 3, 1890.

**MEASLES SUPERVENING UPON URTICARIA PIGMENTOSA.**—A. Morel-Lavallée reports the case of a patient treated in the Hôpital St. Louis, who was infected with measles by another patient. The period of incubation was exactly fourteen days. The measles exanthem appeared only sparsely, but the temperature reached 104°, with severe bronchitis. The simultaneous occurrence of measles and urticaria pigmentosa is very rare. Unna has published the only other recorded case.—*Monatsh. für prakt. Dermatol.*, Bd. 9, No. 12, 1889.

**ACTION OF SALICYLIC ACID ON THE BLOODVESSELS.**—Dr. Linhart, of Vienna, treated an otherwise healthy woman, suffering from sub-acute rheumatism with constant relapses. Among other remedies she often received salicylate of soda, though she strenuously objected to it, as it regularly produced dyspeptic symptoms and pains of contraction in the sacral region, so that sitting, lying or standing was painful, and stooping impossible. Usually, her menstruation was painless, moderate, lasting four to five days; when taking the salicylate, they antepone from three to seven days, and are very copious, with nearly unbearable pains in the sacral region and over the symphysis, with bearing-down pains. The nearer to the approach of the menses she took the salicylate, the more copious and painful was the menstruation. French authors report that the salicylates paralyze the bloodvessels and, whenever indicated, they combine it with small doses of fluid extract of ergot to inhibit this paralyzing effect.—*Wein. Med. Presse*, 49, 1889.

**INHALATIONS IN PHTHISIS.**—Schreiber has demonstrated that the infiltrated portions of the lung in phthisis have lost their respiratory functions. To make the treatment by inhalation it is necessary that the medicament must be brought into contact with the diseased structure. Hence the healthy portions of the lungs must be compressed. In the incipency of phthisis, the healthy portion is usually the lower lobes. Guenther causes compression by strapping the lower portion of the chest with a soft, wide flannel bandage during the inhalation of the kreosote or the hydrofluoric acid, as the case may be. This practice results in a diminution of the number of râles, and changes the character of the sputa.—*Centralbl. f. Klin. Med.*, 47, 1889.

**RENAL AFFECTIONS DURING INFLUENZA.**—According to Fiessenger, different renal affections may be observed during influenza; among these may be mentioned glomerulitis with albuminuria, acute hæmorrhagic nephritis without œdema, and acute parenchymatous nephritis. The acute hæmorrhagic nephritis, which might be mistaken for a renal congestion, is here only a complication of the epidemic disease. In renal congestion the pains are more severe, and we do not have the bronchial râles belonging to the influenza. Acute Bright's disease was met with in two cases, and both recovered. The prognosis of all these cases is favorable; milk-diet and rest in bed will generally effect a cure in two weeks. It may be worthy of mention that influenza whose parasitic nature yet needs elucidation, has renal affections as sequelæ analogous to those met with after other infectious diseases.—*Gaz. Med. de Paris*, 22, 1889.

**MENTHOL IN NASAL DIPHTHERIA.**—In a very severe case of nasal diphtheria, Dr. R. Cholewa thought it worth while to try menthol, as it acts remarkably well in relieving acute swelling of the nasal mucous membrane. He saturated surgical cotton with a 20 per cent. menthol oil, introduced it into the nostrils, and left

it there. In both cases in which he tried this treatment the nasal diphtheria disappeared. At the same time the formation of a membrane in the fauces was prevented.—*Memorabilien*, October, 1889.

**ARSENIC IN THE TREATMENT OF LYMPHADENOMA.**—Berger, of Paris, claims that operative measures have but little influence in the curative treatment of lymphadenoma. As soon as one tumor is extirpated, another one appears. He therefore has more confidence in internal measures, giving large doses of Fowler's solution internally, and injecting arsenious fluids subcutaneously. In several cases decided benefit followed the treatment, though a perfect cure was attained in but one instance. Even these results he thinks better than those obtained by surgery.—*Allgem. Med. Centr. Zeitung*, 98, 1889.

**DANGER OF STROPHANTHUS IN RENAL DISEASE.**—On examination of sections of the kidney after experimental poisoning with extracts of strophanthus, Dr. Ergasse invariably found the kidneys hyperæmic—partly in the cortex, partly in the medullary zone, but chiefly at the tips of the pyramids. He therefore warns us that, clinically, we must bear in mind that where there is coincident nephritis, preparations of strophanthus are contra-indicated, otherwise an increase of the renal trouble may readily supervene. There is pretty general agreement that the action of the drug is most satisfactory in mitral disease, care being always taken that the degeneration of the myocardium has not proceeded too far. Hence it is best not to prescribe it in advanced stages of heart disease, especially when this is accompanied by arterio-sclerosis and interstitial nephritis.—*Medical and Surgical Reporter*, January 18, 1890.

**TWO CASES OF UREMIA AFTER DIPHTHERIA.**—Cassel reports the case of a young girl, aged five years, suffering from diphtheria, who, on the fourth day of her illness, had blood and albumin in the urine. Death occurred on the thirteenth day of the disease, with uræmic manifestations, as convulsions, dropsy, etc. Shortly before death a right-sided hemiplegia appeared, the exact cause of which could not be detected at the autopsy. The only pathological changes discoverable were a parenchymatous nephritis and œdema of the pia mater. The second case was that of a girl thirteen years of age, suffering from diphtheria of the fauces and vulva. During her convalescence the urinary secretion diminished, excessive albuminuria appeared, along with convulsions. Death occurred on the twentieth day of the disease. Glomerulo-nephritis and fatty degeneration of the heart were found *post-mortem*.—*Allgem. Med. Central. Zeitung*, 98, 1889.

**EMOTIONAL NEUROSIS CURED BY HYPNOTISM.**—A healthy boy, aged twelve years, was punished on account of failure to recite his lessons at school. While receiving the castigation he fell down without losing consciousness, and could not speak or use his lower extremities. His physician tried both medicinal and electrical treatment without accomplishing anything. The boy understood fully what was spoken, but could not utter a word in reply. He could open his mouth and move his tongue, but, although there was no tremor, he could not speak. Sensation was somewhat diminished in his lower extremities, and the patellar tendon reflexes were weaker than normal. He denied having any pain by shaking his head negatively. Hirt now hypnotized the boy. Earnestly and repeatedly he suggested to him that he could speak, that he had only forgotten words during the past few days, and commanded him to repeat the words slowly, "And—now—I—can—speak—to—you," assuring him that henceforth he could speak as well as ever before. When the boy was brought out of his trance he spoke readily. Liebanlt, of Nancy, teaches that two troubles should never be removed simultaneously during the same hypnotic state. So, in a few days, the boy was hypnotized once more, when it was suggested to him that for the past few days he had only been tired and weak, and that now he could walk and run as well as ever before. Arousing him from his trance, Hirt made him get out of his bed, and led him around the room, moving faster and faster, the boy during this procedure not showing the least evidence of ataxia. This case was evidently one of emotional neurosis; there could not have been any anatomical lesion in the cerebro-spinal nervous system. How suggestion cured is a mystery.—*Wien. Med. Presse*, 45, 1889.

**CHOREA TREATED BY ELECTRICITY.**—A child, nearly fourteen years of age, suffered from severe chorea. When brought to Prof. Gautier he had taken any

quantity of bromide of potassium, chloral, antipyrine, and sulphur baths. He had been confined to his bed for three months; he had inco-ordination of all his extremities, and choreic twitching of his arms and face; he was unable to speak. He had to be fed, dressed and undressed; there was incontinence of urine. Twenty-six applications of the constant ascending current from sacrum to nucha, of eight to ten minutes' duration each, and increasing from eight to twelve milliamperes in strength, cured the patient, who is now able to speak and write without hesitation, and has regained his former intellectual brightness.—*Bullet. Med.*, 91, 1889.

**BROMIDE OF POTASSIUM IN EPILEPSY.**—Prof. Benedict has not much confidence in the medicinal therapeutics of epilepsy. In organic forms of the disease, that is, those dependent upon malformations of the skull, the prognosis is always bad. The bromides may lessen the frequency of the convulsions, but their administration only serves to increase the intensity of the seizures. Such treatment eventually becomes absolutely injurious, as patients taking large quantities of bromides work mentally only with great difficulty, and mental work is important for mental development. The bromides are absolutely contra-indicated in cases in which the convulsions recur at long intervals.—*Centralbl. f. Nervenheilk.*, 22, 1889.

**OLIVE OIL IN GALL-STONE COLIC.**—Rosenberg, of Berlin, recommends the olive-oil treatment of gall-stone colic in all cases where there are severe pains in the hepatic region, enlarged liver, typical colicky attacks, icterus with unbearable itching of the skin, loss of appetite, etc. He prescribes: *Ol. olivarium*, 200 grammes; menthol, 0.5 grammes; cognac, 20 grammes; 2 yolks of eggs finely pulverized. This dose he repeats in two days. Thus far he has treated twenty-one cases by this method, in nineteen of which he was successful.—*Wien. Med. Presse*, 47, 1889.

**MASSAGE IN THE TARSALGIA OF ADOLESCENTS.**—Landerer, of Leipzig, considers that this painful affection arises from some functional disorder of the muscles. He finds that strengthening of these parts by massage is productive of very satisfactory results. In practicing this procedure he first percusses the *tibialis posticus* at the inner side of the calf, then the *triceps suras*, and finally the sole of the foot. The same parts are then forcibly kneaded, effort being made to affect the deep-seated layers. Finally the foot and leg are rubbed centripetally. The manipulations are at first lightly made. As the operation is continued the various movements are made with more force.—*Berliner Klin. Wochenschr.*, 47, 1889.

**CORYZA SPASMODICA.**—Fenykowsky describes the case of a young woman who had, seven years before, an attack of intermittent fever, which was cured with quinine in the usual manner. Since then she has had daily, after rising in the morning, severe attacks of sneezing, which continue until she is perfectly exhausted. Milder attacks occur in the evenings. Sulphate of quinine in combination with bromide of potassium gave some relief, so that the attacks now come only every third day, and each paroxysm consists of but about twenty sneezes instead of fully two hundred as before.—*Allgem. Med. Centr. Zeitung*, 92, 1889.

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## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

**DIAGNOSIS OF PAPILLARY ABDOMINAL CYSTS.**—Olshausen states that a characteristic sign for the diagnosis of a papillary cyst in the abdominal cavity is the broad base and development of the tumor behind the uterus, and which carries that organ up in front of it out of the cavity of the true pelvis.—*Centralblatt für Gynäkologie*, No. 1, 1890.

**ALBUMINURIA AND PREMATURE SEPARATION OF THE PLACENTA.**—In a lecture on Internal Hemorrhage from Premature Separation of the Placenta, G. Budin gives as his opinion that, in the very great majority of cases, it is primarily associated with albuminuria. In this he agrees with several German authors. In regard to treatment, whether labor should be induced at once or interference be de-

layed, he believes must depend on the circumstances of the case. In this he differs from Schröder and Spiegelberg, who advise immediate interference.—*Leçons de Clinique Obstétricale*, 1889.

**CHLOROFORM IN OBSTETRICS.**—In a chapter on the use of chloroform in obstetrics Budin states that he frequently resorts to chloroform, which he uses merely to produce analgesia without loss of consciousness, and never complete anesthesia. A few inhalations are sufficient for the purpose. He has never experienced bad results, even in cases complicated with diseases of the heart or lungs, and very little effect in delaying labor.—*Leçons de Clinique Obstétricale*, 1889.

**PARALYSIS OF THE UPPER EXTREMITIES IN THE NEW-BORN.**—Paralysis of the upper extremities in the new-born is most commonly due to injury of the fifth and sixth cervical nerves communicating with the deltoid biceps and supinator muscles, and is commonly caused by the traction of the first and second fingers over the neck in extracting the child in breech presentations. The paralysis is more frequent on the side corresponding to the stronger traction of the first finger. The next most common cause is compression of the nerves with the forceps. Other observations show the following causes: Pressure of the clavicle on the nerves; compression of them by the cord around the neck and direct traction on the extremity. Paralysis of the entire brachial plexus is rare. In mild cases the paralysis disappears spontaneously. In others, electrotherapia is necessary for a considerable period of time.—*Leçons de Clinique Obstétricale*, 1889.

**HYPNOTISM AND SUGGESTION IN LABOR.**—Curvard and Secheyron report a case of a woman delivered under the influence of hypnotism and suggestion. The commencement of labor was painful; a short time after she became unconscious, and showed no sensitiveness, even in the second stage of labor, unless waked up, when she complained of severe pain. She also felt the last three pains when the head passed through the vulva, but these were the only ones she could remember when labor was completed. Some other experiments were equally successful, but many of them were quite unsuccessful. It was found essential for success that the patient becomes susceptible to hypnotism by previous training. The use of a shining object and pressure on the bulbi were the means employed for hypnotizing the patient.—*Centralblatt für Gynäkologie*, No. 1, 1890.

**RUPTURE OF PELVIC ARTICULATIONS DURING LABOR.**—S. Remy reports two cases of relaxation and rupture of the pelvic symphyses. In the first, there was a relaxation of the left sacro-iliac synchondrosis in a spontaneous labor and birth of a large girl. The injury produced severe pain in attempting to stand up. A strong binder was applied over the pelvis, which gave great relief, and recovery took place after some months. The rupture of the symphysis pubis in the second case took place with loud cracking during the forceps extraction of a large child in a generally contracted pelvis. Recovery required many months. Nineteen months later the patient gave birth easily to a child without assistance.—*Centralblatt für Gynäkologie*, 1, 1890.

**A NEW SYMPTOM OF COCAINE POISONING.**—Richardson reports a remarkable symptom of poisoning by cocaine. A woman, in whose nose he injected a 10 per cent. solution of cocaine, had severe erotic excitement. The same symptom appeared, to a less degree, a few days later from merely painting on the solution.—*Journal Am. Med. Assoc.*, September 14, 1889.

**HYDRASTIS CANADENSIS IN MEMBRANOUS DYSMENORRHOEA.**—Jordan reports a case of membranous dysmenorrhœa cured by hydrastis canadensis. The patient had suffered for eighteen years from membranous dysmenorrhœa, which had been treated in vain with tannin pencils, intra-uterine cauterization with blue stone, iron baths, dilatation of the cervix, opiates, etc. She was given twenty-five drops of the fluid extract of hydrastis canadensis twice a day, beginning eight days before each menstruation. She was cured in one year.—*Centralblatt für Gynäkologie*, No. 2, 1890.

**VAGINISMUS CURED BY THE GALVANIC CURRENT.**—A woman, aged twenty-two years, suffered from dysmenorrhœa since puberty. Though married five years, coitus had been impossible, as every attempt was followed by most severe spasmodic contractions of the perineal muscles, and as all gynecological treatment failed, she

became unhappy and melancholia set in. The introitus was of normal appearance, but the frequent spastic contractions of the perineal muscles, which came on spontaneously, without being touched, were remarkable, and she acknowledged to have felt these twitchings for years. A large quadrangular kathode was applied on the abdomen and a round anode upon the introitus vaginae, and a weak current passed every second day for four or five minutes at each sitting. Steady improvement followed, and after two months she was cured. Another woman, aged twenty-seven years, suffered from dysmenorrhœa and copious menstruation. Though married for several months, coitus was impossible, and the vain attempts caused vaginal irritation and leucorrhœa. On account of contractions of the perineal muscles, similar to those in the first case, the same treatment was successfully carried out. In both cases it also greatly relieved the pains during menstruation. At the beginning of treatment stronger currents are better borne than later, as during the morbid state the perineum shows less sensibility than after the removal of it. V. Campe finds galvanic treatment of great benefit in pruritus vulvæ.—*Centralbl. für Gyn.*, 50, 1889.

**THE CONDITION OF THE ENDOMETRIUM IN CARCINOMA OF THE VAGINAL PORTION.**—From a careful examination of fifty specimens of the uterus with carcinoma of the cervix, which were removed by hysterectomy, Ernst Saurenhaus makes an excellent report, from which the important features can be summarized as follows: The epithelial cells on the surface of the uterine cavity rarely show any departure from the epithelium of the normal endometrium; in some cases there were marked signs of regressive metamorphosis. In atrophy of the mucous membrane, the intercellular substance showed large numbers of small, short spindle cells united by taut processes, between which were round cells in great quantity. The utricular glands were often excessively increased in comparison to the normal, particularly near the uterine muscle. The interglandular substance contained a large amount of round and spindle cells.

The round cells were most frequent in the cases of more acute inflammation and irritation, and were often seen in large masses as a small cell infiltration. The spindle cells occur in cases which run a more chronic course, and especially in atrophy of the endometrium at or after the climacteric.

In several hundred preparations scarcely any were free from spindle cells. These alterations of the mucous membrane of the uterine cavity in cases of carcinoma of the cervix uteri show no departure from those alterations of the glands or cells which are commonly seen in benign endometritis without the complication of malignant disease, and there is no reason for declaring them to be of a cancerous or malignant nature. This conclusion can only be reached by extensive observation. C. Ruge has arrived at the same opinion since his article was published in 1880 in the *Zeitschrift f. Geburt. u. Gyn.* These investigations of Saurenhaus appear much more thorough than those of Abel, who thought he found evidence of sarcoma in the lining membrane of the uterine cavity when there was malignant disease of the cervix.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd., xviii., 1, 1890.

**CAUSES OF PLACENTA PREVIA.**—R. Kaltenbach divides the causes of *placenta previa* into two groups. First, interference with the resting of the ovum in the folds of the decidua vera from chronic endometritis in old, and especially multiparous, women, or the presence of fibroids or carcinoma of the uterus. Second, absolute or relative enlargement of the placental site in twin pregnancies; in anomalies of the form of the placenta or uterine cavity; in uterus bicornis and unicornis. In addition to these well-known causes he mentions a third, the development of the placenta inside the decidua reflexa on the lower side of the ovum, instead of its usual development in the decidua serotina. He also describes some interesting specimens of development of *placenta previa* obtained early in pregnancy, which were found in uteri removed for malignant disease.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd., xviii., 1, 1890.

**RESECTION OF THE SACRUM.**—A good *résumé* of the new operation of *resection of the sacrum* with removal of the uterus, tubes, small tumors and emptying of abscesses is given by Bernhard v. Beck; four cases of total extirpation of the uterus, one case of peri and parametric abscesses, one of double pyosalpinx and one small fibroid in the cul-de-sac of Douglas. These cases were operated on successfully by Hegar, with the exception of one death from total extirpation.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd., xviii., 1, 1890.

**CYSTS OF THE WOLFFIAN DUCTS.**—In an interesting report and *résumé* of the literature on this subject Gustav Klein mentions the following diagnostic points: (1) one or two layers of tissue in the cyst wall; (2) topographical relations; (3) general extension of cyst along the long axis of the vagina and uterus, or in the broad ligament horizontally beneath the Fallopian tube.—*Zeitschr. für Geburtsh. und Gynäk.*, Bd. xviii, 1, 1890.

**THE INFLUENCE ON THE FŒTUS OF SYPHILITIC INFECTION IN THE LAST HALF OF PREGNANCY.**—P. Steffert reports two cases of primiparæ infected with syphilis during the last half of pregnancy. One was "cured" by the injection and the other by the inunction method. Both were delivered before full term; one of a dead, macerated fœtus; the other of a child which died two hours after birth. Both infants showed unmistakable signs of syphilis and infection from the mother. These cases are instructive, showing facts which are disputed or questioned by such high authorities as Schröder, Zweifel, Lusk and others.—*Zeitschrift für Geburtsh. und Gynækol.*, Bd. xviii, 1, 1890.

**THE ORIGIN AND DEVELOPMENT OF MYOMA OF THE UTERUS.**—R. Roeriger gives an excellent *résumé* of this subject and the results of much original work in the same direction. His investigations are in regard to the histology of very small as well as large myomas with control preparations from normal uteri at different periods of life. He comes to the conclusion that the primary growth of the myoma arises from the muscular fibres of the finest arteries of the uterus. He finds no evidence of Tait's assertion that a myoma has a central artery. In very careful sections of three tumors having numerous peripheral arteries he could find no trace of any arteria centralis. He was unable to obtain a uterus and myoma intact for the injection of vessels. He recognizes the soft and hard varieties of myoma (fibroid) also known as the red and white, and found an abundance of smooth muscular fibres.—*Zeitschr. f. Geburtsh. u. Gynækol.*, Bd. xviii, 1, 1890.

**STATISTICS OF DEATH FROM PUERPERAL FEVER AFTER OBSTETRICAL OPERATIONS**, have been compiled by Hegar as follows: Artificial separation and manual extraction of the placenta by introducing the hand within the uterus shows a mortality of 7.1 per cent; after versions, 5.3 per cent.; after forceps operations, 2.2 per cent.; breech extractions, 0.7 per cent. These statistics are not new, but will bear repeating to show the value of expression rather than extraction of the placenta. Pajo has reported the cases of sixty-eight women in whom the placenta was not delivered; sixty, i.e., nearly all, of these women died. In one hundred and twenty women in whom the placenta was removed there were only four deaths. Colmstein draws attention to the fact that adherent placenta is commonly diagnosed through ignorance when it does not exist. The most common form of genuine adhesion is about the edge of the placenta and it is very rare that more than a small portion of the placenta is actually adherent.—*Archiv. für. Gynäkologie*, 3, 1889.

**TOTAL EXTIRPATION OF THE UTERUS PER VAGINAM** shows excellent results at the Dresden clinic. Münchmeyer reports from the clinic the following remarkable results. In one hundred and ten total extirpations of the uterus, only 6, or 5½ per cent, died. Of these there were fifty-two operations in succession without a death. In ninety operations for carcinoma uteri only four (5 per cent.) died. Of the seventy-six women who recovered, ten have died from a return of the disease and four from other causes. Of the remaining sixty-two women, only one failed to report and submit to an examination; only three showed any recurrence. It should be said that these cases include some recent operations which excluded, will show the following number of cases in whom there was no recurrence of the disease according to the time which had elapsed from the time of the operation to the examination:

No return, 5½ years after the operation,	.	.	.	.	1 case.
" 4½ "	"	"	"	"	2 "
" 4½ "	"	"	"	"	2 "
" 3½ "	"	"	"	"	3 "
" 3½ "	"	"	"	"	1 "
" 3½ "	"	"	"	"	6 "
" 3 "	"	"	"	"	2 "
" 2½ "	"	"	"	"	3 "

No return, 2½ years after the operation,	. . . . .	2 cases.
" 2½ " " "	. . . . .	2 "
" 2 " " "	. . . . .	3 "
" 1½ " " "	. . . . .	3 "
" 1½ " " "	. . . . .	3 "
" between 1 and ½ year,	. . . . .	4 "

The statistics of the clinic show that 64.5 per cent. of such cases have remained free from recurrence for more than two years.

The following statistics of the eighty cases operated on for carcinoma are interesting in regard to the traumatism of labor and the ætiology of this disease:

1 patient had been in labor	. . . . .	1 time.
12 " " "	. . . . .	2 "
13 " " "	. . . . .	3 "
8 " " "	. . . . .	4 "
6 " " "	. . . . .	5 "
7 " " "	. . . . .	6 "
4 " " "	. . . . .	7 "
5 " " "	. . . . .	8 "
3 " " "	. . . . .	9 "
1 " " "	. . . . .	10 "
1 " " "	. . . . .	11 "
3 " " "	. . . . .	12 "
2 " " "	. (including miscarriages)	13 "
2 " " "	. " "	14 "
1 " " "	. . . . .	15 "
1 " " "	. . . . .	17 "
1 " " "	. . . . .	18 "

Seventy-one of these cases report one or more pregnancy, and 59 per cent. had been so more than three times.

In fourteen cases there was marked infiltration of the parametrium, yet there are only three in which the cancer has returned, showing that such an infiltration is not a positive contra-indication to the operation. In three cases the utero-sacral ligaments were infiltrated, and in two of these the patients died from return of the disease. While this may be accidental, it goes to show the increased probability of recurrence when such an infiltration is present.

In regard to the situation of the disease and recurrence after total extirpation of the uterus: In this, the operations of the last year are not included. In carcinoma of the body of the uterus it recurred in 33½ per cent. of the cases; of the colum (neck), of the uterus, it recurred in 40 per cent.; of the vaginal portion (cervix), it recurred in 20 per cent. As a matter of comparative frequency of the disease and of the parts affected, it may be stated there were nine carcinomas and two sarcomas of the body of the uterus, twelve carcinomas of the colum, and fifty-seven of a fungoid character on the cervix, probably epithelioma.

In the treatment of uterine myomata, ergotin, curetting, dilatation of the cervix with laminaria tents, enucleation, castration, and partial or complete removal of the uterus, have been found valuable. Electrical treatment has not been tried to any extent, and no opinion is expressed, other than mentioning that total extirpation was performed in two cases for whom electrical treatment had been employed for some time, without the clinic, with no success.

Treatment with ergotin, curetting, and dilatation of the cervix has been only palliative, and not very satisfactory. Enucleation is liable to be followed by the development of another fibroid, as the uterus very often contains a number of them. Castration, when practicable, relieves most cases, but the writer urges total extirpation as the most radical treatment of all.

Richelot's clamps for hysterectomy are not used there, and the opinion is that there is not sufficient evidence that hæmorrhage will not occur after their removal. In extirpation of the carcinomatous uterus, there need be no hesitation about removing diseased portions of the bladder; injuries of that viscus have been found to heal rapidly.—*Archiv. für Gynäkologie*, Bd. 93, H. iii., 1889.

(The entire article is very instructive. Prof. Leopold is a fine operator, as I had the pleasure of observing in visiting his clinic last summer. Yet this article has the decided flavor of surgical treatment and brilliant results, which are far from likely to be obtained in the practice of ordinary surgeons.—G. R. S.)

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**FOR THE PREVENTION OF BLINDNESS.**—Of the different bills now before the New York State Legislature, of interest to the medical profession, there is one which deserves favorable consideration. This is entitled an Act for the Prevention of Blindness, and provides that every midwife or nurse who has charge of a case of purulent ophthalmia of infancy shall be obliged to report the same promptly to the local health physician; and failure to do so is to be punished by a considerable fine or punishment, or both. According to the report of a special committee on blindness, appointed by the State Society, it appears between 1870 and 1880, while the population of the entire United States increased 30.09 per cent., the number of blind increased 140.78 per cent. During the same time, blindness in New York State increased 8.2 times as rapidly as the population, and during the last five years of that decade it increased 13.7 times as rapidly. The report of this committee gives due weight to the fact that such statistics are apt to be misleading, but concludes that in all probability the increase of blindness is much more rapid than the increase in population. However this may be, there are two undisputed facts which, of themselves, would be sufficient to warrant the adoption of any such measure as this act contemplates. In the first place, it has been established by a large number of examinations of the inmates of blind asylums in different parts of Europe, as also by similar investigations made at the New York State institutions for the blind at Batavia and in New York city, that about one-fifth of all these cases of blindness are those which resulted from purulent ophthalmia of infancy. Next we have the clinical fact that, when these cases receive proper treatment in the early stages of the disease, recovery results in all but an exceedingly small proportion. In other words, the destruction of the eye from purulent ophthalmia must now be regarded almost invariably as due to carelessness or neglect. The object of this legislation is therefore to forcibly impress upon nurses and midwives the importance of the disease, and by calling the attention of the parents to the fact that the slighter forms of the inflammation are something more than a "cold in the eye," as it is often termed, to have them seek for their children that medical advice and attention which this class of cases promptly demands.—*New York Medical Record*, February 8, 1890.

**ACUTE INFLAMMATION OF THE LACHRYMAL SAC.**—Dr. David Webster, in the New York State Medical Society, February 4, 1890, said, that as acute dacryocystitis or abscess of the lachrymal sac often came primarily under the notice of the general practitioner, it was important to make a correct diagnosis. The fact that several cases of the affection lately coming under the speaker's notice had been diagnosed and treated as facial erysipelas had led him to speak on the subject. The differences between it and erysipelas were that, in acute dacryocystitis, the principal swelling and tenderness were immediately over the lachrymal sac, at the side of the nose, and just below the inner canthus. In facial erysipelas there was no more swelling over the sac than in the rest of the inflamed area. In acute dacryocystitis the inflamed area was always confined to the side of the nose, the upper part of the cheek, eyelids and conjunctiva. In rare cases the cornea was affected. Facial erysipelas often included in the area of inflammation the forehead, temple and sometimes the upper lip, while the temperature ranged higher and the physical disturbances were more profound in erysipelas than in dacryocystitis. Questioning would usually elicit the fact that the patient had had watery eye or running over of tears for a long time. It would seem that chronic catarrh of the lachrymal canal predisposed the sac to acute purulent inflammation. The speaker urged early incision at a point between the caruncle and the inner canthus, where there was only the conjunctiva and the sac wall to pass through. After the subsidence of the swelling the canaliculus could be slit and the strictures divided, probes being passed at intervals.—*New York Medical Journal*, February 8, 1890.

**RUPTURE OF THE MEMBRANA TYMPANI.**—Carl Beinert (Inaug. Dissertation, Halle, 1889), states that in the Halle clinic, from April, 1884, to April, 1889, out of six thousand three hundred and forty-five cases treated, forty-seven instances of traumatic rupture of the drum-head had been noticed. Twelve of these were direct



and thirty-five indirect ruptures. The direct ruptures were the result of penetration with straws, twigs and the like, clumsy efforts at extraction of foreign bodies, and in one case a burn from molten steel. Indirect ruptures were caused by boxing the ears in thirteen cases. As other causes, were mentioned explosions near the ear, diving, and Politzer inflation and severe blows upon the head and chin, accompanied by other serious lesions to the head. In the treatment, in order to prevent all irritation and possible infection of the wound, Prof. Schwartze avoids injections and instillations, allows but little exploration of the parts, and that only with surgically clean instruments. The meatus is lightly filled with iodoform or sublimate gauze, which must never reach to the surface of the membrane, and be held in place with the typical antiseptic coverings. The patient is kept quiet, regular stools secured, not allowed stimulants or tobacco, and warned to avoid forcible blowing of the nose. If middle ear inflammation sets in, the treatment follows the ordinary methods.—*Archiv Ohrenheilkunde*, December, 1889.

**EXCISION OF THE DRUM-HEAD AND THE TWO OUTER OSSICLES, FOR THE CURE OF PERSISTENT OTORRHOEA.**—Ernst Witzell (Inaug. Dissertation, Halle, 1889) gives twenty-eight cases in which this operation was carried out in the Schwartze Clinic at Halle. The indications given for the procedure are the same as laid down in Schwartze's text-book, viz., suppuration of the tympanum, and caries of the ossicles. In five cases, the operation was done in both ears. In seven cases, the suppuration was entirely cured, and in six the improvement was marked. When, in spite of the removal of the membrane and bones the suppuration was not relieved, there was found to be a purulent condition and caries of the drum deeper in, or of the cells of the mastoid process. In the latter condition the mastoid was opened six times, with cessation of discharge in two of them. The influence on the hearing was various. In thirteen cases the hearing was much improved, in two somewhat lessened in acuity. The remaining cases were not influenced in the hearing power. The operations, in spite of careful antiseptic precautions, were usually followed by reaction and suppuration. The only untoward result of the operations was a facialis paralysis in two cases which, however, disappeared in seven weeks.—*Archiv Ohrenheilkunde*, December, 1889.

**TWO CASES IN WHICH GRAVE SYMPTOMS FOLLOWED THE INSTILLATION OF COCAINE INTO THE TYMPANUM.**—In the first case, after a paracentesis of the drum-head, a few drops of cocaine solution were worked into the tympanum in order to lessen the pain of an intended division of intratympanic adhesions. Within five minutes, the patient was seized with vertigo, trembling and nausea, lost her equilibrium, fell almost senseless to the floor, and remained so for several minutes. On attempting to rise, the same symptoms were repeated. It was only after four hours that the patient was able to assume the upright position, and with help stagger to her home. In the second case, identical symptoms lasted one and a half hours. Both patients were perfectly well the following day.—Dr. Suarez de Mendoza, in the *Revue Laryngologie*, No. 10, 1889.

**THE INFLUENCE OF THE TELEPHONE ON THE HEARING.**—Dr. Cl. Blake believes that the frequent and prolonged use of the telephone by persons affected with middle ear disease, is apt to further impair their hearing power, the reason given being the unavoidable accommodative effort the ear is obliged to make to catch the lessened intensity of tone received through the instrument and the confusion arising from the whirring sound inseparable from the present instrument.—*Zeitschrift für Ohrenheilkunde*, Bd. 20.

**OBSTRUCTED NASAL BREATHING IN CHILDREN.**—Obstructed nasal breathing, the cause of which lies not only in the various diseases of this cavity, but also in those of the pharynx and the naso-pharynx, materially interferes not only with the physical but the mental development in children. It can be shown that a continuous nasal obstruction in children frequently results in loss of will-power, indisposition to work, loss of memory, inability to concentrate the thoughts, peevishness, and general mental depression. Children so afflicted, if successfully treated in time, exhibit a most wonderful improvement in these particulars. The speaker would hence desire to see every child who appears lacking in physical or mental capacity, before he is placed in his appropriate class at school, undergo a careful examination of his ears, nose and throat at the hands of a competent specialist in these departments.—Dr. Bresgen, in September meeting, Naturforscher u. Ärzte, Heidelberg, *Internationales Centralblatt Laryngologie and Rhinologie*, January, 1890.

## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

**A NEW METHOD OF REMOVING BILIARY CALCULI.**—Senger calls attention to the unsatisfactory results following operations on the gall-bladder. Of the several methods in vogue, that of establishing a biliary fistula has been most frequently practiced, but owing to the discomfort following this procedure, Langenbuch proposed and practiced the entire removal of the organ. Although Langenbuch's method is apparently a little safer, it has found but few advocates. The dangers of the operation, whatever method be chosen, are hæmorrhage and peritonitis. The former is due to the many adhesions that are usually found and the peculiar watery consistency of the blood in this trouble; the latter to infection, which can usually be prevented by careful antiseptics. The ideal operative procedure is that first introduced by Küster, which consists in suturing the bladder-walls and dropping it back into the abdominal cavity. This method, although the ideal one, is not at all practical, because the walls of the gall-bladder are the seat of pathological changes, in consequence of which they do not heal kindly, and it is usually followed by peritonitis, non-union of the wound and the escape of bile. This led the author to institute a series of experiments on the lower animals, and having arrived at a satisfactory result, he carried out his idea on the human subject. The operation is performed as follows: An incision, about 12 cm. long, is made through the right linea semilunaris down to the peritoneum, and after controlling all hæmorrhage, this is opened and stitched to the integument. The gall-bladder is carefully freed from adhesions, and drawn outward and upward on to the abdomen. This necessitates raising the liver slightly. The abdominal wound is now closed, and further interference postponed for 24 or 48 hours, at the end of which time the wound will be found to have united. The gall-bladder is now opened, the calculi removed, and the wound carefully united by a Lembert suture. If union does not take place, the edges can be freshened and stitches reapplied. After healing is assured, the bladder is reintroduced into the abdominal cavity by opening the freshly united abdominal wound, or it may be allowed to remain in place, whence it gradually retracts into the abdomen, leaving but a slight nodule.—*Berliner Med. Wochenschrift*, January 13, 1890.

**THE SURGICAL TREATMENT OF CHOLELITHIASIS**—Crede bases his views on his experience with seven cases. They were all females who had suffered for several years without any alleviation. Five of them had steadily lost flesh and strength during the six months prior to the operation, were unable to do work of any kind and demanded operative interference. The youngest was twenty-four and the oldest seventy-six years of age. In two cases a biliary fistula was established, one of which closed, while in the other a small fistula remained. In two cases Küster's method was practiced, and in the remaining three the entire bladder was removed (Langenbuch). In two of the cases of cholecystectomy the bladder was bound to the liver by firm adhesions, which were divided by means of the Paquelin cautery. All of his cases recovered without reaction or complications of any kind, excepting one who had a profuse hæmorrhage on the sixth day. The edges of the wound were united by a few sutures, the centre being left open, packed with iodoform gauze and allowed to heal by granulation. The advantage of the open method can be readily seen, as it gives free vent to any blood, wound secretion, or necrotic liver tissue, and, if hæmorrhage does occur, it can be more readily controlled. The author states that it is possible to determine in many cases whether the gall bladder is adherent or not to the liver by percussion and palpation. If it can be mapped out, it may be regarded as proof that it is filled with fluid and not completely adherent. In these cases extirpation is not necessary and cystotomy, with immediate suture, is indicated. If enlargement of the liver can be made out, the gall-bladder will usually be found adherent and sufficiently diseased to require removal. In determining the size of the gall-bladder, one should consider the time of examination, for even a diseased bladder is always larger and more easily made out just before and after an attack of biliary colic. The author's observations confirm those of Odin, that notwithstanding the general improvement of health, the patients at first lose in weight, but soon rapidly gain again.

The following are his conclusions :

In advanced disease of the gall-bladder cholecystotomy is indicated. If the organ is still capable of performing its functions and the ducts not obstructed, cystotomy, after Küster's method, should be practiced, and in feeble or aged patients a biliary fistula should be established.—*Archiv. für Klin. Chirurgie*, Bd. 39, Heft 3, 1889.

**EFFECTS OF EXTIRPATION OF THE GALL-BLADDER.**—Oddi, after removing the gall-bladder from three large dogs, noticed the following symptoms: Bile pigment was found in the urine; the stools were fluid in character, deeply colored, and mixed with mucus; the appetite was much impaired. The writer explains these changes as being due to a continuous flow of bile into the intestine; the coloring matter is absorbed, while the constant presence of the secretion on the mucous membrane produces a catarrhal condition. In addition to this the emulsifying process of fatty matters, and consequently the entire digestive function is interfered with, owing to a decrease of the bile at the point where the chyme enters the duodenum. This observation is supported by the fact, that in an animal in which Oddi established a gastro-biliary fistula, with ligature of the ductus choledochus the operation was followed by the appearance of copious bile pigment in the urine, but no diarrhoea nor diminution in weight. On the contrary the weight increased. This is thought to be due to the fact that bile accumulated in the stomach and was emptied together with the chyme into the duodenum. It is interesting to note that a considerable increase in the size of the biliary ducts occurred. This was most marked in a dog killed one month after the operation. In the others killed two or three months later, the hepatic ducts were somewhat enlarged, and the cystic duct was found sacculated, suggesting an attempt on the part of nature to form a new gall-bladder. The author is convinced of the existence of a sphincter of the ductus choledochus, and interprets the behavior of the animals during life and the conditions of the bile ducts found after death to the action of this muscle, which converts the flow of bile from a continuous one to one more nearly approaching the normal.—*Centralblatt für Chirurgie*, 1889, No. 8.

**HYDROGEN DIOXIDE IN SURGERY.**—Dr. T. S. K. Morton has been using the above in general surgery and is of the opinion that it will find a definite position among the antiseptics. The per- or dioxide of hydrogen is a solution of the gas in water. The strength varies, that ordinarily sold, being the saturated solution. The combination is unstable especially in the presence of heat or organic matter. This property of setting free *nascent* oxygen gives it its value in surgery as it will not affect living tissue, not even harming the youngest epithelial cells, but violently attacks and oxidizes all organic matter of lower degree, pus, lymph, micro-organisms, etc. This cannot be said of any other antiseptic. Bichloride of mercury, for instance, when strong enough to destroy micro-organisms, will also destroy newly organized cells. Again, the standard antiseptics do not remove the sterilized organic matter nor penetrate it as deeply as the dioxide, which will eat through any depth of pus, lymph, etc., burning them up as it goes. The bichloride, as is well known, coagulates an almost impermeable layer of albumen which may screen septic matter underneath. While certain bacteria thrive only in the presence of oxygen they probably cannot resist, or at least are not stimulated by this much more powerful and destructive *nascent* form. The agent may prove of value in tubercular disease, to the bacillus of which oxygen is a deadly enemy. It must be useful in all forms of supuration, abscesses, sinuses, purulent ophthalmia, gonorrhoea, cystitis, etc., as well as in the conditions for which it has been used by otologists and laryngologists. What is more, it is absolutely innocuous, so much so that spoonful can be swallowed without effect. It is to be poured on to ulcers or into cavities until bubbling ceases. When bichloride is to be used it should follow the dioxide on account of the coagulum it forms. The peroxide has furthermore a marked hæmostatic effect, turning the blood first bright scarlet and then almost black. The author does not think the dioxide of hydrogen will supplant the bichloride or the other antiseptics.—*Medical News*, December 28, 1890.

**OPERATIVE TREATMENT OF ANCIENT SHOULDER LUXATIONS.**—In an address before the Hunterian Society, Lister presented two cases in which long-standing dislocations of both shoulders have been reduced by operation. He was led to this by the misfortune, on one occasion, of rupturing the axillary artery while trying to correct a similar deformity in the usual way. They were both cases of subcoracoid

luxation of a number of weeks standing, in one instance with marked atrophy of the rotators, and the results were very gratifying, the only defect being inability to elevate the limb above the horizontal level. The operation is performed as follows: An incision is made from the coracoid process downward and a little outward in the interval between the deltoid and pectoralis major. With a curved periosteal elevator all the soft parts are separated from the inner side of the upper end of the bone. Injury to the axillary vessels is thus prevented. If reduction cannot now be accomplished, the head is to be protruded and the rotators detached, when the bone can usually be replaced. If this fail the head can be removed, giving a useful limb, but not as perfect a one as in the former instance. Whenever the prudence of attempts at reduction is in doubt, or such attempts fail, the operation is indicated.—*The Lancet*, January 4, 1890.

**KOCHER'S METHOD FOR THE REDUCTION OF SHOULDER DISLOCATIONS.**—C. Beesley reports two cases in which this method was used and the luxations quickly and easily reduced. The forearm is flexed on the arm, the elbow being gently pressed to the side; the humerus is rotated outward until the forearm is at a right angle with the body; the elbow is then raised and carried inward until the hand touches the other shoulder.—*Lancet*, January 25, 1890.

**FRACTURE OF THE PATELLA TREATED BY MAYO ROBSON'S METHOD.**—J. F. Horne reports a case in which apparent bony union followed the use of the method recently suggested by Mayo Robson. A long steel pin with glass head was passed through the quadriceps tendon close to the upper fragment, another through the ligamentum patellæ. The fragments were then drawn together and held in place by a figure of eight of whip cord. An antiseptic dressing and plaster of Paris splint were then applied. The aftercourse was uneventful.—*The Lancet*, January 18, 1890.

**MAGNESIA ISINGLASS.**—To hasten the hardening of silicate of soda, Englisch proposes the following formula: Slowly boil four parts of a solution of soda isinglass until it is reduced to the consistency of thick syrup and then triturate with it one part of finely-powdered magnesia until the mixture becomes yellowish white. The bandages are laid in this (unrolled) and then rolled, but they must not be exposed to the air over fifteen or twenty minutes before being applied. The limb is first covered with an ordinary bandage, and then with five or six layers of isinglass bandage for the lower extremity and one or two less for the upper. Occasional cardboard or leather strips may be used to strengthen the dressing.—*Wiener Medizin. Wochenschrift*.

**NÆVUS TREATED BY COLLODION.**—Mr. Thomas presented to the Midland Medical Society (December 12, 1889) three cases of nævi treated by collodion (one on back, one over parotid, one over anterior fontanelle). They were covered, together with the surrounding skin, with collodion, which was repeatedly applied. Improvement was so marked as to do away with the necessity for operative interference.

**ATER-EFFECTS OF CHLOROFORM.**—Ostertag, by a series of experiments on animals, confirmed the opinion of Strassmann, that chloroform narcosis of long duration is followed by fatty metamorphosis of many of the internal organs, notably the heart and liver. He also found that it affects the blood, the red corpuscles becoming overloaded with carbonic acid, which is the direct cause of death. The urine contained gall pigment. Chloroform should, therefore, not be used in operations of long duration.—*Berliner Klinische Wochenschrift*, January 6, 1890.

**EXTIRPATION OF GOITRE IN GRAVES'S DISEASE.**—Judging from the results of the few cases in which this operation has been performed, Stierlin is of the opinion that it has a curative effect on the main disease. In other forms of goitre strumectomy is only indicated for the dyspnoea, but in this trouble it may be warranted in the absence of respiratory interference. Tillaux (1880) first reported a cure by this means. Rehn (1884) published three cases, with more or less definite symptoms of Graves's disease, that were relieved or cured by extirpation. Several others are quoted as having performed the operation with encouraging results. Krönlein observed that the rapid and increased heart's action gradually returned to normal, the previous dirotic pulse became katacrotic, and a slight dilatation of the left ventricle disappeared; the nervous restlessness, to a great degree, subsided. The author was unable to make out from these successful operations in exophthalmic goitre any argument for or against the theory of its sympathetic origin.—*Brun's Beiträge zur Klinische Chirurg.*, 1889, Bd. V., Heft I.

## MONTHLY RETROSPECT

OF HOMŒOPATHIC MATERIA MEDICA AND  
THERAPEUTICS.

CONDUCTED BY

CHARLES MOHR, M.D., AND EDWARD R. SNADER, M.D.,

WITH THE COLLABORATION OF

S. LILIENTHAL, M.D.,

HORACE F. IVINS, M.D., AND EDUARDO FORNIAS, M.D.

**INCIDENTAL EFFECTS OF IODUM.**—Malachowski detected in one patient paresthesiæ of the legs, which became very severe, when sitting, and were less felt when walking and especially decreased when lying down. Dr. Proell verified this symptom in a patient whose back was pencilled with tincture of iodine on account of spinal irritation. He could not sit down on the largest easy chair, without spasmodically supporting himself on the arms of the chair; he felt anxious, and always feared he would fall.—*Allgem. Hom. Zeitung*, 25, 1889.

**PROVING OF FERRUM SESQUICHLORATUM.**—Four men took for four weeks ferrum sesquichloratum. A solution containing one half of one per cent. was made, of which they took during the first week thirty drops, the second week sixty, during the third and fourth weeks ninety drops, so that every prover took during the proving 0.473 of the salt. All complained of disturbed digestion, sensation of pressure in stomach, symptoms of congestion, increased cardiac action and oppression in the chest, and still all of them felt better and stronger. The pulse increased in frequency during the proving and then slowly diminished again. One prover suffered from acne and conjunctivitis. For some time after the proving they complained of hebetude and depression, fulness and pressure in stomach, eructations, disturbed defecation, loss of appetite, sensation of debility, and two of them of vertigo after rising.—Prof. Schulz, *Allgemeine Homœop. Zeitung*, 21, 1889.

**EXPERIMENT WITH FERRUM CARBONICUM.**—The well-known chemist, Dr. Kletzenski, of Vienna, gave to several patients the third decimal of ferrum carbonicum, kept them under strict surveillance, so that he could examine their fæces, and in every one he found exactly the same quantity of iron in the fæces, showing that the same quantity of iron is discharged which was taken internally. Proof enough, says Dr. Proell, of the action of infinitesimal doses.—*Allgemeine Homœop. Zeitung*, 21, 1889.

**A PROVING OF NITROUS OXIDE OR LAUGHING GAS.**—In the February number of the British *Homœopathic World*, there appears the following, recorded by Dr. Clarke:

"Some months ago I was requested to give gas to a young lady aged twelve, for the purpose of tooth extraction. She was an unusually long time in going under, and, after the operation, seemed rather dazed. I saw her safely home, but I left town the same day. I did not see her again, and only heard some months after of what followed.

"She became delirious in the evening; screamed whenever she fell asleep; complained of great pain in the chest: a cough came on, and she coughed up blood her feet were put into hot water, and hot water-bottles were placed to the chest. This gave great relief; she described the sensation as a feeling as if something which was obstructing the chest dropped down into the stomach. She was confined to bed for a fortnight. At the present time, although well in other ways, she has a cough in the morning. She cannot lie on the right side. The right side of the

chest is duller than the left, and there is increased vocal resonance and prolonged expiration. She complains of sharp pains in the front of the chest.

"Since this case has been thus unpleasantly brought to my notice, I have heard of several others; and I publish it, in the first place, as a warning against a little-known danger, and, in the second place, that nitrous oxide gas may be thought of as a possible remedy in congestion of the lungs. The right lung was affected in this case, and the relief from heat was very marked."

**MATERIA MEDICA OUTLINES.**—Under this caption Dr. E. V. Moffat, in the January *Chironian*, gives the following:

*Ambra Grisea* is the only drug covering a blue starchy leucorrhœa.

*Anacardium*.—Remember loss of memory; great inclination to swear, and the characteristic plug-like pains, which may press on almost any portion of the body, internally or externally.

*Antimonium Crudum*.—Irritable mental condition (children don't want to be touched or looked at), retarded digestion, with eructations tasting of food long after it has been eaten; white, milk-like coating on the tongue; alternating constipation and diarrhœa, which is often seen in old people.

*Antimonium Tartaricum*.—There is the same peevish, fretful condition of children, most prominently associated with diarrhœal troubles; intense, death-like nausea; persisting vomiting, with feeble pulse; clammy perspiration; profound exhaustion; cough loose and rattling, with very difficult expectoration—it feels as though the next cough would surely raise the mucus, but it doesn't. (Bromine has a similar condition, but it is more laryngeal, while antimonium tartaricum is more bronchial). Clinically we see antimonium tartaricum indicated in bronchitis; frequently in old people; in capillary bronchitis; in catarrhal pneumonia; in croupous pneumonia, in the stage of resolution; in pulmonary œdema, and, rarely, in whooping cough.

*Apis Mellifica*.—Thirstlessness; drowsiness; 5 P.M., aggravation; stinging pains; œdema; ascites; inflammatory swellings, puffy, bright red in color; scanty urine. Clinically we find it most frequently useful in diphtheria, or sore throats; scarlet fever; nephritis; urticaria; erysipelas; malarial fever; œdema of neurotic origin; meningitis with effusion, and serous effusions generally.

*Apocynum Cannabinum*.—Best used in decoction, and, by its diuretic action, will relieve ascites arising from nephritis, cirrhosis of the liver or heart disease.

*Argentum Nitricum*.—Headache as though the bones of the skull would separate, relieved by binding the head tightly (this headache may be of gastric origin or from structural trouble in the nerve centres); ophthalmia neonatorum, or purulent conjunctivitis at any stage, with more pain and burning than in *pulsatilla*; sore throat, which is bright red, sticking pains in the pharynx as from a splinter, with glairy mucus in the throat and mouth. It covers gastric ulcer, gastritis, gastric catarrh arising either from drink or from the abuse of sweets. There is a craving for sweets, which disagree with the patient. The dyspepsia is flatulent, with violent, noisy eructations; gastralgia, radiating pains, sometimes from ice-cream and generally worse after eating. There is tympanites, with green diarrhœa, stools resembling chopped spinach, which may be the result of fright. We also find urethritis, with a profuse, purulent discharge. It is useful in certain structural lesions of the nerve centres, giving muscular inco-ordination, convulsions and other symptoms.

*Arnica Montana*.—The most frequent clinical applications of *arnica* are for the results of bruises, blows or falls. It produces peculiar sore, bruised pains, with ecchymoses, and thus is homœopathic to the condition. In concussion of the brain or cord from traumatism, it is prominently indicated (though *hypericum* will often take its place). Indeed, it may be called for in similar lesions of any of the viscera. It is a powerful absorbent of hemorrhagic exudations, either ecchymoses or clots, and will frequently relieve chronic troubles dating back to long antecedent blows, bruises or injuries which may have acted as exciting causes. In the way of special symptoms we may note hot head or face, with a cold body; nose-bleed, especially after washing the face; eructations, generally having an odor of sulphuretted hydrogen, and intestinal flatus with the same fetor; whooping cough, when the child cries before the paroxysm; a general tendency to visceral hemorrhages, principally from traumatism; the bed feels too hard; and, finally, a liability to the formation of small, painful boils, coming frequently, one after another.

**HOMŒOPATHY PHRENOLOGICALLY CONSIDERED.**—Under the above caption Dr. George W. Sherbino gives the following:

1. The organ of amativeness is influenced by *cannabis indica*, *cantharis*, *conium*, *hyoscyamus*, *kali bromatum*, *lachesis*, *lilium tigrinum*, *murex*, *nux vomica*, *phosphorus*, *phosphoric acid*, *sabina*, *staphisagria*, *stramonium*, *veratrum album*, and others.

2. Combativeness, by *aconite*, *agaricus*, *alcohol*, *ambra*, *antimonium tartaricum*, *arsenicum*, *aurum*, *baryta carbonica*, *belladonna*, *bromium*, *bryonia*, *calcareo carbonica*, *cantharis*, *causticum*, *chamomilla*, *china*, *elaps*, *ferrum*, *hyoscyamus*, *ignatia*, *kali jod.*, *lachesis*, *lycopodium*, *nux vomica*, *petroleum*, *platina*, *ruta*, *sepia*, *staphisagria*, *stramonium*, *sulphuric acid*, *tarentula*, *thuja*, *veratrum viride*, *viola tricolor*, *zincum*.

3. Destructiveness, by *belladonna*, *hyoscyamus*, *merc. j. f.*, *opium*, *veratrum album*.

4. Acquisitiveness, by *bryonia*, *calcareo carbonica*, *calcareo fluorica*, *nux vomica*, *pulsatilla*.

5. Firmness, by *belladonna*, *calcareo carbonica*, *chamomilla*, *lycopodium*, *nux vomica*, *nitric acid*, *sanicula*, *silica*, *stramonium*, *sulphur*.

6. Caution, by *alcohol*, *aconite*, *arsenicum*, *cuprum metallicum*, *hyoscyamus*, *nux vomica*, *opium*, *pulsatilla*, *stramonium*.

7. Benevolence, by *alcohol*, *anacardium*, *coffea tosta*.

8. Conscientiousness, by *arsenicum*, *aurum*, *hyoscyamus*, *ignatia*, *nux vomica*, *silica*.

9. Hope, by *aconite*, *calcareo carbonica*, *ferrum* (alternating with sadness, *raph.*), *sulphur*, *veratrum album*.

10. Marvellousness, by *stramonium*.

11. Imitation, by *stramonium*.

12. Form, by *belladonna*, *cuprum*, *stramonium*.

13. Causality, by *stramonium*.

14. Veneration, by *coffea*.

15. Secretiveness, by *agaricus*, *alcohol*.

16. Mirth, by *aconite*, *anemone*, *aurum*, *asafoetida*, *belladonna*, *crocus*, *hyoscyamus*, *ignatia*, *nux vomica*, *pulsatilla*, *phosphorus*, *sepia*, *stramonium*.

17. Adhesiveness, by *belladonna*; sweet outpourings of, *alcohol*.

18. Self-esteem, by *ignatia*, *platina*.

19. Philoprogenitiveness, by *oxalic acid*.

**REMEDIES FOR HÆMORRHAGIC MALARIAL FEVER.**—Dr. J. H. Henry, in an interesting article appearing in the February number of the *Northwestern Journal of Homœopathy*, gives the following medicines as of service in the treatment of hæmorrhagic malarial fever:

*Tartar emetic* and *Veratrum viride* when there is high fever, pulse full, strong, and quick; useful in the first stage.

*Gelsemium* for flushed face, bright, sparkling eyes, quick fever and great restlessness.

*Aconite* (tincture) in preference to either of the others, if the fever is of a low grade.

*Belladonna* in passive congestion, in often repeated doses until relieved—*Atropia* is better.

*Arsenicum*—Jaundice, black blisters, pimples, coldness of the limbs, general coldness with parched-like dryness of the skin, or with profuse sweat; scanty, dark-yellow, or greenish dark-brown urine, difficult micturition; hæmaturia; constipation; dark-green or dark-brown diarrhœa, or dark stools; burning, acrid, violent and unquenchable thirst; fever commencing at night, with coldness.

*Carbo vegetabilis* when complexion becomes grayish-yellow, continued nausea with disposition to vomit, blisters in the mouth, with eructations; dark-red urine, as if mixed with blood; reddish, turbid urine; chilliness with thirst, fever, with thirst during cold stage; jaundiced blotches on the skin.

*Ergot* for yellowish complexion; bleeding at the nose; vomiting black bile in a state of decomposition; constant stretching and retching, with vomiting of a crude bilious substance; constant ineffectual efforts to vomit, constant thirst; want limbs stretched; constipation; putrid and fœtid colliquative diarrhœa; brown-colored diarrhœa; suppression of urine; difficult micturition, with constant urging in the bladder; hæmorrhage from the urethra.

*Sulphuric acid* is sometimes indicated.

*Nitrate of Silver* for violent vomiting.

**EUPHRASIA IN OPHTHALMIA.**—Dr. Beaumont says: "Euphrasia solution is

almost a panacea in the local treatment of muco-purulent ophthalmia, when there is much mucus of a tenacious, stringy character; matter floats over the eye; external canthi are excoriated and red.—*Medical Era*, January.

**CALCAREA CARBONICA IN DISEASES OF THE NOSE AND THROAT.**—In the January number of the *Journal of Ophthalmology, Otolaryngology and Laryngology*, Dr. Charles L. Cleveland, after recapitulating some of the vague and indefinite symptoms of calcarea carbonica in diseases of the nose and throat, gives some special conditions which appear to indicate the medicine: Excessive redness of the mucous membrane of both nose and throat (not a congestion, nor a chronic venous hyperæmia, but rather an evenly-diffused heightened color); excessive sensitiveness to local applications, especially to stimulants, absorbents and astringents. When this condition exists, attended or not by such glandular hypertrophy or sluggish resolution of inflammatory products—the results of acute attacks—which characterize the strumous diathesis to which this drug so broadly corresponds, together with the temperament and the characteristic perspirations, the doctor has obtained splendid results in old hopeless cases who had been sprayed and douched *ad infinitum* and *ad nauseam*.

**KALI BICHROMICUM IN DISEASES OF THE NOSE AND THROAT.**—Dr. Charles L. Cleveland thinks we expect too much from this remedy at too early a date when kali bichromicum is administered for atrophic rhinitis and allied disorders. He gives it in fair-haired, scrofulous patients, with liver symptoms, scanty urine and rheumatoid pains.—*Journal of Ophthalmology, Otolaryngology and Laryngology*, January.

**MOSCHUS IN SINGULTUS.**—Dr. Cowperthwaite was treating a typhoid patient who was very low, and was troubled with frequent attacks of singultus. *Moschus* 2x trituration was given with most brilliant results, after hyoscyamus and other remedies had failed. The hiccoughs ceased after the first dose was administered.—*Medical Era*, January.

**OPIUM IN TYPHOID, COLIC AND ASTHENIC PNEUMONIA.**—Dr. Conrad Wesselhoeft says: Opium is homœopathic to the following cases: (1) Abdominal typhoid; sleep, with happy dreams, burning heat and red face; or unconsciousness, with happy delirium; obstinate constipation from torpor, or liquid, involuntary black stools. (2) Colic, with distension of bowels, tenderness and bruised sensation, throbbing pain and protracted constipation. (3) Asthenic pneumonia, with slow congestive period, or becoming stationary at any stage, especially in the aged possessing feeble resistance to disease; moaning, rattling, short breath. But even opium will not cure if the patient is already in *articulo mortis* from heart paralysis. Dose, from a drop of the tincture to the second decimal.—*Medical Era*, January.

**NITRIC ACID IN CONGESTION OF THE LIVER.**—Dr. Tessier, in the *Bulletin de la Soc. Med. Homeo. de France*, January 1, 1890, reports a case of this affection, in which nitric acid, 1st, gave prompt relief to the epistaxis, restored the urine and stools to the normal, relieved the paroxysmal pains, cleared the conjunctivæ and skin, and stopped the vomiting so that a condition, which had lasted two months, was well at the end of thirteen days, with the exception of a pain around the chest on the mammary line. This was relieved by ranunc. bulb. 6, in two days. The doctor suggests that nitric acid has been too much neglected in such cases, in deference to china, calcarea and berberis.

**CURE OF A FIBROID TUMOR.**—Dr. Criquelion, of Mons, relates in the *Revue Hom. Belge*, the history of a very interesting case of a large tumor of the right side. It was very hard, movable, painless, and was as large as a baby's head. The menses were irregular and profuse. Platina 6, conium 6, micania guaco 6 and lapis albus 6 were prescribed, each to be taken one week. In six months a decrease was easily detectable; with the exception of a short time when sepia 6 was substituted for the platina, the same treatment was continued for four years. At the end of this time there was not a trace of this once enormous fibroid, and the doctor states, "the woman was radically cured."—*Hom. Monatsblatter*, No. 10, October, 1889.

**MICANIA GUACO** is a South-American creeper, which is there used as the chief remedy in snake-bites. It has been used with good effect in diarrhœas—similar to those indicating veratrum album. *Micania guaco* is also used in stubborn ulcers.—Dr. Criquelion, *Revue Hom. Belge*, October, 1889.



**EFFECT OF OLEUM LIGNI SANTALI.**—Fuerbringer found that, in the dose of two drops, three times daily, it produced renal pains, painful urinations, severe stitches in the skin, a roseola-like eruption, and the whole skin seem to be impregnated with the odor of the oil.—*Allgem. Hom. Zeitung*, 21, 1889.

**CASTOREUM IN DIARRHŒA.**—Castoreum has cured watery or green mucous stools in delicate nervous children, who weaken under summer heat or during dentition, and who will not rally under the usual remedies. There is colic before the stool. The child seems to double up with the pain. There is also twitching of the muscles, with great exhaustion. It may be found of especial use where the case has progressed well to a certain point, and there seems a lack of nervous reaction, tending to unduly prolong the convalescence.—*Journal of Obstetrics*, January.

**ALOES IN CHRONIC DIARRHŒA, WITH PROSTATIC DISCHARGE.**—A blonde, of twenty-seven years, suffered for a year with a diarrhœa coming on every evening at seven o'clock, and also at other times; he was compelled to answer the urging at once, as he had no confidence in his sphincter ani, although at night he could pass flatus (which was always hot), without difficulty or fear; free discharge of prostatic fluid after stool. Aloes cm. cured in a short time.—Dr. William P. Wesselhoft, *Homœopathic Physician*, January.

**OXALIC ACID IN TUBERCULAR HÆMOPTYSIS.**—Dr. Tessier treated in the hospital Saint Jacques a young man of twenty-six years, who complained, for a year, of loss of strength and sprightliness, of inappetency and insomnia; he looked pale and emaciated. On July 1st he began to have hæmorrhages. Ipecacuanha and millefolium did nothing. Phosphorus 30 and iced milk produced a transient amelioration, but the bleeding returned after lachesis 12th, and he was then put on oxalic acid 6th, which was continued until he could be discharged apparently well; four months afterward the bleeding had not returned. According to Burnett, oxalic acid acts on the heart, and in the respiratory organs it affects especially the larynx, the connective tissue of the pleura and the inferior portion of the left lung; the pulse becomes rapid and feeble, and aphonia may set in. Burnett cured with it alone a case of pleuro-pneumonia of the left side, and a case of asthma depending on a localized congestion. Burt mentions among its characteristics angina pectoris and dyspnœa, and in the *Lancet* may be found a case of poisoning, with præcordial anguish, feeling of suffocation and hæmoptysis.—*L'Art Médical*, December, 1889.

**SARRACENIA PURPUREA IN SMALL-POX.**—In the *Revue Hom. Belge*, of July, 1889, Dr. Martiny calls attention to an article by Dr. Mouremans in the same journal of 1875, in which he recommends this remedy especially as a preventive of small-pox, but also as a curative agent. Dr. Martiny has confirmed its use as a prophylactic, and in one case of developed small-pox he found it to act in apparently arresting the march of the disease, the pustules did not suppurate and appeared as if aborted, or, as the original author puts it, "The disease appears arrested in its evolution." The remedy is much and successfully used in the treatment of small-pox by certain savage peoples. Coffee is a powerful antidote to sarracenia.

**CERIUM OXALICUM IN EPISTAXIS AND DYSMENORRHŒA.**—Cerium oxalicum is recommended for epistaxis, arising from abdominal plethora, and is also useful in dysmenorrhœa, especially in young robust girls with scanty discharge, colicky pains, and tenesmus at the appearance of menses. May not in some cases the epistaxis be vicarious?—*Allgem. Hom. Zeitung*, 21, 1889.

**FERRUM MURIATICUM IN AMENIA AND SEMINAL EMISSIONS.**—Dr. Woodward says: The muriate of iron 3x has become a standard remedy with me in the treatment of girls with arrested menstruation, and of boys with tendency to seminal emissions or copious urination at the age of puberty.—*Medical Era*, January.

**CHIMAPHILA IN CYSTITIS.**—Dr. G. N. Seidlitz, in the February *Northwestern Journal of Homœopathy*, details three cures of cystitis wrought by the administration of *chimaphila* in the lower preparations. Frequent urination, with much mucous deposit in the urine, the doctor considers characteristic for this drug.

**TARENTULA IN MASTURBATION.**—In the February *Homœopathic Physician*, Dr. Filipe Ascot de Tortosa, tells of a girl who consulted him for fatigue that she experienced on the slightest exercise. Menstruation normal, slightly scarce, good

constitution, a healthy color. Suffered from slight cephalalgia at times; a light dry cough; slight pain in the præcordial region; slight palpitation. Hydrocyanic acid and cactus grandiflora failed; but the doctor at last suspected masturbation as a cause of the symptoms, and prescribed *tarentula* 6. In a few days she was well.

**SPECIAL REMEDIES IN PUERPERAL FEVER.**—Dr. T. Griswold Comstock, in the February *Medical Era*, in an article on "Toxæmic Puerperal Disease," mentions the following medicines:

*Aconite* may be used at first, when the patient has a high fever, with bounding pulse, great excitement and restlessness (a dose every half hour).

*Veratrum Viride*.—Should be used with extreme caution. High pulse—120 or more.

*Baptisia*, if the breath is fœtid, and the lochial secretions especially offensive.

*Turpentine* for tympanites, with profuse and uncontrollable diarrhœa.

*Quinine*, if the disease sets in with a severe chill, followed by intense fever and sweats.

*Belladonna*, *bryonia*, *arsenic*, *muratic acid* and *rhus toxicodendron* may all be found useful.

**ZINCUM VALERIANICUM IN NEURALGIC DYSMENORRHEA.**—Dr. Corresta T. Canfield claims that valerianate of zinc has proven curative in neuralgic dysmenorrhœa. There is pain in either ovary, accompanied with nausea and neuralgic headache. Neuralgia of the ovary, worse during the menses. (Zincum metallicum, pains relieved during the menstrual flow.) In one case, a lady, aged thirty-four, no children, suffered at her menstrual periods with an excruciating drawing pain in the left ovary. Pain usually accompanied by nausea, vomiting and headache. Cured by *zincum valerianicum* 12x. In another case, a woman who had syphilis in her younger days, was nearing her climacteric. During her menses she experienced a gnawing, drawing pain in the right ovary. Pain extended through to back, to right of spinal column, just above the sacro-iliac symphysis. *Zincum valerianicum* 2x always relieved these symptoms.—*Journal of Obstetrics*, January.

**LILIUM TIGRINUM AND SEPIA COMPARED.**—Lilium approaches somewhat to sepia in its effects upon the circulation, particularly the nervous, and still more especially does it stand near to sepia in those nervous affections that depend upon circulatory disturbances of the female genitalia. Both have nervous irritability, depression, and a feeling that she must be busy about something. But with all these symptoms common to these two drugs there are essential differences. The lilium patient finds relief in diverting her mind by busying herself; while the sepia patient has relief from many of her nervous symptoms by violent exercise. It is, in the former case, a sexual erethism, produced by the pelvic venous stasis, that is relieved; in the latter, relief is general by favoring the venous circulation of the pelvic organs, nervous erethism being but slight and associated with lessened venereal passion.—*Journal of Obstetrics*, January.

**VALERIANA IN HYSTERIA.**—Valeriana has been so much used and so abused by the old school that homœopathic physicians are too apt to neglect it. But it and its salts occupy a definite place in gynecological practice, and especially in the treatment of hysteria. It is not so much adapted to hysterical spasms, with unconsciousness (as with musk and asafoetida) as it is to a general state of nervous and vascular excitement. Both mind and body are in a condition of nervous irritation. The patient is lively, joyous, talking rapidly, with rapid chasing of thought after thought. Sometimes, she imagines she is beset with dangers, or surrounding objects seem strange. She suffers from headache, giddiness, and restlessness. Her muscular organism is so irritated that she cannot keep quiet; she must move about. The same state influences her pains.

The provings show twinging, drawing, cramp-like, stinging, or darting pains, all worse when she sits, and better when she walks. The circulation, too, is excited; her head feels full to bursting; constant heat and uneasiness; dry heat in the evening while sitting; flashes of heat. She is wide awake and restless all night, falling into a dreamy sleep toward morning. Digestion also suffers in the general nervous disturbance. Before dinner she has a taste as of fœtid tallow, while early in the morning, on awakening, the taste is flat and slimy. Nausea, as if a thread were hanging in the throat, arising from the region of the umbilicus and gradually ascending to the fauces. Bloating abdomen.—*Journal of Obstetrics*, January.

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MATERIA MEDICA DIFFICULTIES.

BY E. M. HOWARD, M.D., CAMDEN, N. J.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

THE science of therapeutics rests upon an accurate knowledge of but three things. 1st. A knowledge of the human organism as it exists during health (anatomy and physiology). 2. The human organism as modified by disease (pathology). 3d. The human organism as modified by drugs (physiological materia medica). The first of these is pretty well understood. The second is but just attaining its proper position as a science. The latter is still in its infancy and beset with difficulties. Therapeutics can never be elevated to such a degree that its governing laws shall be recognized and accepted by all creeds in medicine until these obstacles to the study of the true and reliable physiological effects of drugs shall be removed.

I do not wish now to speak of the well-known difficulties in the way of eliminating imaginative and other false results from the homœopathic drug provings. Nor will I consider the herculean task required by the necessity that such reprovings shall be made as will place the results beyond the cavils of scientific observers.

These things have been talked about and written upon so much that one is almost afraid to bring forward any new provings, or make any contribution whatever to our already overburdened drug symptom-list.

We are therefore, by necessity, compelled to content ourselves at present with gathering up the accumulated material of the centuries, and I wish to speak particularly of the obstacles that the student

meets in sifting out the real knowledge existing in this general medical literature, and to call attention to the difficulty there is in determining just how much is fact and how much is theory or unwarranted deduction.

General knowledge of drug effects is first obtainable from the records of cases of poisoning. Nearly all such reports are more or less vitiated by the fact that such cases have usually been under treatment, so that it is difficult to determine just how much of the condition is due to the poison, and how much it may have been modified or altered by the treatment applied.

Having, however, eliminated this source of error, we are confronted by a still more formidable one.

There are, in most poison cases, two kinds of symptoms apparent: first, the manifest chemical or mechanical effects of the drug, and second, the real physiological impression. I am not aware that any attempt has ever been made to separate these two distinct results of poisonous materials, but it is evident to me that such a division must be made before we can intelligently fit them into any therapeutical scheme or law.

Suppose a person suffering from the effects of any of the corrosive poisons, like sulphuric acid. In such a case we shall find actual destruction of tissue wherever the drug has touched. It is evident that all such loss of tissue will give rise to more or less symptoms. But it is also evident that no symptom, directly or indirectly produced by this destruction, could have any possible bearing upon the future therapeutical action of the drug. All such conditions could teach us about the drug would be its local, mechanical or chemical possibilities. If the smallest drop touches the glottis, we may set up all the symptoms of spasmodic croup, and yet the drug could not be shown to bear any possible relation to the glottis or larynx under any therapeutic theory. It is a pure mechanical effect.

Again, give a person repeated doses of subnitrate of bismuth; the result is constipation of the bowels, due to the direct mechanical clogging of the intestines by the powder. Notwithstanding the fact that this drug is made use of to check loose bowels, it shows no more physiological relationship to the intestines than does a splint to a broken bone, and any discussion regarding its use in such cases must be along a similar line, viz., as to the possibility of so applying as not to produce local irritation or loss of function. This is a mechanical question, not a therapeutical one. It will be a great gain when the materia medica student of the future shall be able to say, in every

case, this symptom is a pure physiological effect, that is only a chemical or a mechanical one; but there is thus opened up to us a most difficult field for investigation.

There is another phase of toxic action which is not sufficiently well differentiated. Such poisons as kill suddenly, like prussic acid, or large doses of aconite, produce symptoms of collapse so quickly that there is no time for real physiological symptoms to arise. Hughes alludes to this fact in discussing certain drugs, but this matter needs extended consideration. The rapid lowering of the temperature, slowing and weakening of the pulse, cold perspirations, etc., are only conditions showing that the nervous system has met with some terrible shock, against which it can make no struggle.

True physiological drug effects are the results of a conflict between drugs and living tissues. Whenever the vital forces have been overcome, and have given up the struggle, then we have a state of collapse. All dangerous drugs will have this effect if the dose be sufficient. It is, however, a debatable question, whether such effects have the slightest bearing upon any legitimate therapeutical use of the drug. The first attempts of the old school with the use of aconite in fevers, was based upon this variety of drug-effect, viz: Its rapid lowering of the temperature. But it was soon discarded and pronounced dangerous, only to come into general use, when the small doses were borrowed from our school. It is on similar grounds that the use of the more modern antipyretics may be discussed, and there is evidence that they will soon be discarded on account of their dangers.

Herein lies the fallacy of many of the so-called physiological experiments, especially such as are undertaken to determine drug-effects upon blood-pressure and temperature. That a drug applied to a nerve terminal, lessens either blood-pressure or temperature, proves nothing as to its real physiological effects. It is only comparable with any other serious external injury.

It seems to me therefore, that before we can know the real therapeutic bearings of these remedies, we must eliminate from their records of poisoning, not only their chemical and mechanical effects, but also, all such symptoms as have appeared after the life struggle has really ended, leaving only collapse and death.

Having settled such facts to his satisfaction, the student of *materia medica* will naturally turn to the standard old-school authorities, to find such accumulated facts as they have garnered from the experience of the ages. That there are facts, important facts, to be found

here which are not well learned from any homœopathic literature and facts that have been neglected by the homœopathic school, I think no one will question. The physician must know the mechanical and chemical uses and doses of drugs; he must be familiar with their palliative possibilities, and where else shall he find the ordinary effects of continued medicinal doses?

But the real searcher after positive facts will here meet serious difficulties. The old-school writers mostly discuss drugs from their therapeutical side, and they are chiefly concerned with their effects in disease. Quinia is the great antiperiodic. Its effects are studied in this clinical light. Because clinical experience shows its power over malarial fevers, its febrifuge qualities are deduced. There is no hint as to its ability to produce feverish conditions. Mercury has been proven clinically to be the great antisypilitic, hence its so-called alterative properties are inferred. And so it happens, that in studying the effects of drugs in disease, we miss their pure uncomplicated physiological effects. It is this that blinds the old-school observer to the possibility of the existence of a therapeutic law. His reasoning is backward from clinical light to therapeutic theory.

It is surprising, also, when one is searching for facts, to find how much space, in standard authorities, is devoted to discussions and theories as to the manner in which drugs act. Such theorizing is all very well in its place, and is a necessity to the experimenter in drugs, as well as in other sciences, but facts are far more important to the practitioner, and it would not be safe to base methods of practice upon a theory. It will be found no easy task to cull from this rich structure, the real kernels of truth which exist there.

There is not time to discuss the well-known difficulties involved in the study of the schema forms of the homœopathic materia medica. Richard Hughes has done much to solve these questions and the new *Cyclopædia of Drug Pathogenesis* is paving the way for a much greater advance in rendering the subject more intelligible. But the ideal materia medica has yet to be written. Perhaps the man is not yet born who will be able to write it. It seems to me, however, that the trend of progress must be along the lines here indicated and that we may hasten the preparation of such an ideal work, by striving to simplify and reduce to actualities the knowledge that is now possessed.

## A CASE OF SYRINGOMYELIA WITH SYMPTOMS OF NEURITIS OF LEFT BRACHIAL PLEXUS.

BY JOSEPH T. O'CONNOR, M.D., CLINICAL PROFESSOR OF NERVOUS DISEASES  
IN THE NEW YORK HOMŒOPATHIC MEDICAL COLLEGE.

(Read before the New York County Homœopathic Medical Society, February 18, 1890.)

FREDERICK G—, a strongly-built man, æt. 47, native of Germany, admitted to Ward's Island Homœopathic Hospital, September 18, 1889.

On board ship three years ago he fell a distance of ten or twelve feet, striking squarely on his back. He was not apparently injured by it, and was entirely well until July 17, 1889, on which date, while working on a farm on Long Island, he was sunstruck. He was taken to a hospital on Long Island, and remained there three weeks, then was three weeks boarding in New York, then was in Bellevue Hospital for three weeks, and was transferred as above stated to Ward's Island Hospital, suffering from intermittent fever.

At the time of admission to the latter hospital he complained of pain in the back of the neck and occiput; moving the head was painful; was troubled with palpitation of the heart, and loss of breath on exertion. His legs swelled; both hands were swelled; first noticed this swelling while in Long Island Hospital. After the sunstroke, he had great pain in the back on bending forward.

The intermittent fever was very severe; temperature after the chill being, at times, 105° F. He had to be moved into a room where he could be more quiet than in the ward. The fever was eventually cured by giving baptisia  $\phi$ , as a regular medicine, and 5 grains of quinine three times a day.

About November 1st he was able to get about, and his general health has been good since. The only thing he complained of, at this date, was weakness and numbness of the left arm. This weakness began in the shoulder region.

Examined by Dr. O'Connor, December 5, 1889. Inspection shows distinct atrophy of the first interosseous hand muscle, wasting of thenar eminence, fibrillary contractions in the deltoid muscle; profuse sweating of the axillary integument, and of the palm and palmar surface of the fingers; all of left side.

There is distinct paralysis of the deltoid.

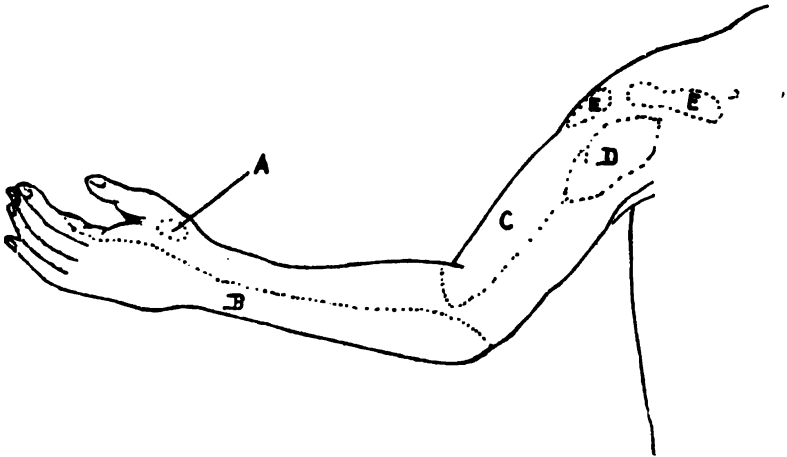
He is unable to lift the arm outward and upward, except partially by excessive action of the trapezius muscle; cannot supinate or pronate the arm; cannot rotate the arm, except to a trifling extent, either inward or outward; extensor action upon the hand is impaired, the hand is half flexed, the power of spreading the fingers or of extending them is gone, nor can he touch with the end of the thumb the tips of the fingers. Lateral action of the hand to the radial side

and to the ulnar side is retained, and there is some flexor power in the hand and fingers, as the grasp is simply weakened, not gone.

Drawing the humerus forward and inward across the chest, or backward and inward, is done partially; to bring the two shoulder-blades closer together is easy. When the arms are held forward, the inner edge of the left scapula stands out from the deep structures of the back, but is not changed in its direction, there being no rotation of the scapula.

*Sensation.*—The tests of the different forms of sensibility gave curious and, at times, discordant results. When touched lightly with cotton, tactile sensation (of this light touch) was found to be

FIG. 1.



A. Atrophy with reaction of degeneration (?) and anæsthesia; B. Complete anæsthesia; C. Sensibility to temperature lost; D. Anæsthesia for temperature complete, with partial for touch; hot was here perceived as cold; EE. Temperature sensibility lost, but tactile sensibility retained.

lost for the second and third phalanges, excepting on the radial border of the first finger; but something akin to allocheiria was noticed, in that when the skin of the second phalanx was touched the sensation was referred by the patient to the first phalanx, and, at times when the lateral aspect of one of the second phalanges was so touched, sensation was perceived in the analogous surface of the next anterior finger; that is, if the third finger was touched in the spot named, the sensation was perceived in the second finger as stated. This allocheiric variation of sensibility is noticed in different parts of the arm.

The ulnar nerve can be felt greatly thickened behind the olecranon, but it is not tender to pressure.

There is loss of tactile sensation to light touch on the lower bicipital aspect of the upper arm, and on the upper two-thirds of the deltoid region. Loss of pain-sense (to pin-pricks) on the an-



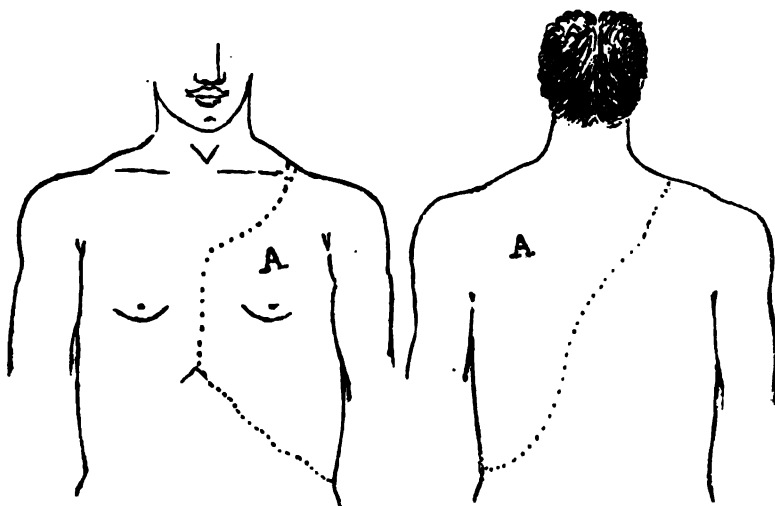
terior and ulnar aspect of the forearm, on the deltoid and triceps regions.

December 7th. Tested electrically. All parts respond to Faradic current, but less than normally, except in first interosseous space, where no response can be obtained; no reaction of degeneration, except, possibly, in first interosseous.

Loss of sensation for heat or cold in different areas of arm.

January 3d.—A re-examination for temperature-sense shows some spots in which this is lost, although that for touch (deep impression) is retained. On the deltoid region, the touch of a hot body is felt as cold. On the ulnar side of the arm, both anteriorly and posteriorly, there is loss of all sensation of touch, temperature and pain; and on the whole dorsal aspect of the arm the sensation of pain (ex-

FIG. 2.



AA. Area on which Faradic sensibility is lost and tactile sensibility retained.

cept as stated of the ulnar half) is decidedly lessened. All sensation, except that of deep pressure, hence of touch, temperature, and pain, is lost on both dorsal and palmar aspects of hand, except on the radial side of index finger and radial side of thumb.

Cremasteric reflexes are retained and are vigorous.

Knee-jerks exaggerated; no ankle clonus.

Triceps reflex in left arm easily obtained; no exaggeration of left wrist reflexes.

Pupils are equal, and react to light.

Tongue is protruded straight.

January 29th. Re-examination:

Flexor power of forearm on arm weak, forearm can be brought up one-third way.—Biceps, brachialis ant. Nerv. muscul. cutan.

Extensor power weakened.—Triceps. N. musc. spir.

Pronation gone.—Pronator quad. P. teres. N. musc. spir.

Supination, to mid-position.—Supinator longus. S. brevis. N. musc. spir.

Abduction of arm gone, can partly raise arm forward.—Deltoid. N. circumfl.

Adduction present to some extent, but cannot adduct in front of body, nor to back.—Pectoralis maj. N. ant. thor. Latiss. dorsi. N. subscap. long.

Cannot touch middle of buttock of the same side, nor opposite shoulder. External rotation of upper arm, good.—Teres. minor. N. axill. Infra spinatus N. subscap.

Internal rotation, poor.—Subscapularis N. subscap. brev. Teres maj. N. subscap. brev. Latiss. dorsi. N. subscap. long.

Extension of hand on forearm gone, but with last two phalanges flexed, is fair.—Common extensors. N. musc. spir.

Extension of first phalanges, fair (common extensors), and of second and third phalanges (interossei) of first finger and middle finger partly; not at all of fourth and third.

Separation of first finger from middle is possible (long extensor), N. musc. spir.; not the others (interossei).

Adduction of metacarpal of thumb very faint (adductor pollicis).

Can touch tip of thumb to tips of first and second fingers, not to others.

Grasp of hand practically gone.—Flexors. N. median et ulnar.

Lateral extension of hand at wrist possible, in both directions, but lessened.—Ext. carp. rad. brev. et long. Ext. carp. ulnaris. N. musc. spir.

Flexion at wrist, weakened.—Flexor carpi ulnaris. N. ulnar. F. carpi radialis. N. median.

Loss of muscular sense in the two ulnar fingers; muscular sense present in all other parts of hand and arm.

Faradic current in strength great enough to be painful in right arm, is only felt slightly over most of left arm, with the exception of a spot about an inch and a half in diameter in ulnar half of dorsum of hand, where it is well perceived, and in whole ulnar half of front and back of left arm where it is not felt at all.—N. musc. spir. Musc. cutan. Int. cutan. Circumflex.

Faradic current of normally painful strength is felt slightly on radial half of palm and not at all on ulnar half.—N. ulnar., N. median.

Faradic current is not felt on skin covering first interosseous space and ball of thumb; it is felt on the two phalanges of thumb.—N. median.

Faradic current of strength that is normally painful is felt but slightly on the whole extent of the back of the neck, from one ear to the other and from hair-line to trunk, N. supra clavicular; this partial and special form of anæsthesia is limited below the neck on

the right by a line starting from the junction of neck and trunk, passing obliquely downwards to the left, crossing the spinal column midway between the two scapulæ, then descending somewhat to left of spinal column till about three inches below inner angula of scapula and passing horizontally around the left side. On the left, the limiting line begins at end of neck, crosses, downward and forward, the trapezius region to about the mid-line of sternum and then passes down to about end of the bone, and curves around the side to meet the line previously described.—N. intercostal; ant., post. and external branches.

At a spot about an inch in diameter, above the spine of left scapula, the sensation is absolutely gone. In all the described region of Faradic anæsthesia pain-sensation to pin-pricks is retained, except where stated to be gone in previous examinations.

Faradic current, the electrode being at inner angle of scapula of either side, causes fibrillary tremor of latissimus dorsi and infra-spinatus of same side. Faradic current causes fibrillary tremor of right deltoid as well as contraction. Complains latterly of rheumatic pains in right supra-clavicular region extending to region behind right ear.

There has been some pain in the left arm, but not of great severity; for three nights only, about January 20th, the pain was sufficient to interfere with sleep; its site was the cutaneous distribution from the musculo-spiral nerve.

At the first examination of the patient, I made the diagnosis of syringomyelia, basing it upon the peculiar sensory disturbances and the paralysis and atrophy. The condition producing the special syndrome justifying the diagnosis, is a neoplasm, usually a glioma, within the substance of the spinal cord, and as the growth increases, the nutrition of its central portion becomes less and less, until finally that portion softens, liquefies and is absorbed, so that within the growth a cavity appears. As the growth is chiefly in the gray portion of the cord, it often affects the anterior gray horn, and always the central gray, while very frequently the posterior gray horns are affected. The result of this complex interference with the functions of the gray is that atrophic paralysis is present, sometimes with, sometimes without, the reaction of degeneration; that simple tactile sensation is frequently normal, and that usually the perception of temperature differences (heat and cold) is lost or greatly impaired. A glance at a drawing representing the normal cord in cross section, and showing the region in which are found the tracts for the different sensations as well as the nutritional and trophic (supposed) spinal centres, will make the matter plain. The accompanying drawing is an enlarged rep-

resentation of the microscopic appearances found in a section of the cord from a patient having this disease.

In the case under consideration, the diagnosis was not an easy matter. The limitation, at first sight of the paralysis, both sensory and motor, to the left arm, the remarkable anæsthesia for slight tactile impressions, present over most of the arm, the absolute loss of all sensation on the ulnar half of the arm, together with evident thickening of the ulnar nerve behind the olecranon, would seem to be enough to discredit the first diagnosis, and force us to conclude that the disease is simply a neuritis of the brachial plexus. Such a neuritis is not a rarity. It is at times observed in new-born infants as a result of pressure made by the obstetrician's fingers above the clavicle during the last stage of parturition. At the point named

FIG. 3.



Section of cord, 2d cervical segment from Kronthal's report of a case.—*Neurolog. Centralbl.*, Nos. 20, 21, 22, 1889.

the upper cords of the brachial plexus are exposed to injury, and paralysis of this type has been caused by carrying heavy timbers upon the shoulder. Tumor above the axilla may cause the same symptoms, and injury from using a crutch may affect the nerve-cords.

But a closer analysis of the symptoms themselves shows a condition of affairs not compatible with neuritis, except in a few particulars. The extreme loss of power, without any evident atrophy (except as stated), the remarkable sensory loss which is inordinately great in comparison with the motor phenomena, the loss of certain sensations with preservation of others, are not what we expect in a neuritis. And, in addition, the ready response of the nerves to Faradization at Erb's supraclavicular point, of the musculo-spinal nerve, behind the biceps muscle, of the median nerve on the inner face of the upper arm, and even of the ulnar nerve behind the olecranon (the nerve at this point, it will be remembered, is distinctly thickened

and almost nodular), is not in accordance with what we know of a neuritis of such apparent severity. Hence, from these considerations, we are justified in looking further than the plexus and its cords for the origin of the trouble.

Fibrillary contractions in a muscle, although not thoroughly understood, are associated with beginning degenerative change in it, or after degeneration they show the beginning of improvement. Hence, when found in the deltoid, infraspinatus and latissimus dorsi of the right side, as they were in this case, they point either to the other brachial plexus or to the spinal cord as their source. Further, from the marked lessening of sensibility to a strong Faradic current in the covering of the whole extent of the back of the neck, as well as downwards in the dorsal region, on both sides, we must again exclude disease of the brachial plexus as the ultimate cause. The skin covering the back of the neck is supplied by branches from the three upper cervical nerves, that covering the supraclavicular region from the third cervical, while on the back and sides the anæsthetic area is supplied by the intercostals.

Here, then, we have to go outside of the brachial plexus to account for the sensory loss. The seat must be in the spinal cord, and the changes in the ulnar nerve must be secondary to and dependent upon this.

The trouble in the cord cannot be a myelitis, as there are none of the characteristic symptoms of the latter affection; it is not a growth springing from the membranes, as there is no evidence of compression within the cord; it is not progressive muscular atrophy of spinal origin, anterior poliomyelitis, as the sensory symptoms invalidate that view; it is some infiltrating growth in the gray matter of the cord in its cervical enlargement. Such a condition is now well known; it is probably a gliomatous mass that has affected the anterior gray horn of the left side, destroying some of the large ganglion cells and injuring others; it also involves the middle gray, since it interferes with conduction of temperature and pain sensations. Whether it involves the posterior horns to some extent, cannot be said off-hand, as the loss of tactile sensation may be due to changes secondary in the nerve trunks; and we are very sure that it has not invaded the posterior columns, as the muscular sense is preserved, except in the ulnar distribution.

Such a neoplasm, as it grows, compresses the bloodvessels that supply its centre with nutrition, and soon the centre breaks down, liquefies and leaves a cavity. From this fact the disease-process is

termed syringomyelia; that is, the formation of a cavity in the spinal cord. More than 120 cases have been recorded, with *post-mortem* proof in about 70, of the diagnosis; but a number were wrongly diagnosticated during life. The necessary variability of an infiltrating neoplasm in the direction of its growth must make the symptoms vary in different cases, but the chief symptoms relied upon as diagnostic are the presence of progressive muscular atrophy, paralysis and the peculiar partial anæsthesia, tactile sensation being usually preserved, while at the same time the temperature-sense and often the pain-sense are lost. More than one case has been reported of what appeared to be a brachial neuritis that was really the disease under consideration.

Schulze is stated by Stadelmann\* to have had a case of syringomyelia, in which proliferation of connective tissue was found in the brachial plexus. Fitz† reported a case of progressive muscular atrophy confined to the left arm and shoulder muscles. Here, however, the preservation of tactile sensibility and that for pain, with diminution of thermic sensibility, leads Mme. Dejerine-Klumpke‡ to consider Fitz's case one of syringomyelia. Remak reports§ a case of syringomyelia, in which there was degenerative atrophy limited chiefly to the left hand, with partial anæsthesia, that is for temperature and pain.

Rumpf reports a case|| in which, in 1884, the patient, then aged 35, found that he was losing the power in his right hand, and that the ball of the thumb, as well as the first interosseous space, had wasted. At the same time he noticed that the hand felt "asleep," with sensation of formication; the fingers were numb, and this numbness would last often for a quarter of an hour. He came under treatment of Prof. Erb, in Heidelberg (by electricity), and in a few weeks he had recovered sensation and power, but avoided work with a heavy hammer. In eighteen months the trouble returned, with wasting, numbness and weakness, but more extensive than at first; soon the right leg was affected by the sensory trouble, and on coming under Dr. Rumpf's care, December, 1888, it was evident that he had syringomyelia.

One observer has insisted that remissions are frequent, sometimes to the extent of apparent cure, and he thinks this almost diagnostic

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\* *Neurolog. Centralblatt*, No. 17, 1887.

† *Ueber Saturnine Progressive Muskelatrophie*. Würzburg, 1882.

‡ *Des Polynévrites et des Paralysies et Atrophies Saturnines*. Paris, 1889.

§ *Berliner Klinische Wochens.*, No. 3, 1889.

|| *Neurolog. Centralblatt*, 7, 8, 1889.

of the trouble. In the case under consideration, the patient has improved a good deal,\* especially in the ulnar distribution, but an examination made February 12, 1890, shows increased knee-jerk of left side, faint on right, marked lessening of tactile pain (Faradic) and sensibility, and what is more important, marked loss of muscular power in the left leg. These points had not been specially tested previously, as the patient had always said that there was no loss or lessening of either power or sensibility in the left leg. The temperature-sense is present on left leg, but it is dulled; that is to say, hot or cold impressions are felt less plainly on the left than on the right leg.

The evidence in the present case is overwhelmingly in favor of syringomyelia as the disease-state causing this patient's symptoms, and the prognosis is unfavorable. Cases last from two to seven years, the extension of the growth involving centres in the cord of vital importance.

Treatment of such cases must be wholly symptomatic. The only substance used as a remedy, that is recorded as being in relation to the disease, is *lead*. The origin of the trouble has so often been apparently traumatic, that *arnica* deserves attention as a possible remedy. Apart from these remedies we must treat such cases by using such drugs as seem indicated, without reference to the diagnosis.

Whether the original fall in the present case produced changes in the cord that were aroused into violent activity by the sunstroke three years later, and whether the symptoms of a severe intermittent were, as may be surmised, the general manifestations of a local, rapidly proliferating process in the cord, are questions beyond our present powers of solution.

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### FRAGMENTARY PROVINGS.

BY MALCOM MACFARLAN, M.D., PHILADELPHIA, PA.

(Read before the Philadelphia County Homœopathic Medical Society.)

AT the request of the chairman of your Bureau of Materia Medica I present these fragmentary provings, which were made originally for my own information and use. They are scarcely complete enough

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\* In a report of a case of syringomyelia, the *post-mortem* findings in the cord being given in great detail, by Ira Van Gieson (*Journal of Nervous and Mental Diseases*, July, 1889), the following statement is made: "During the thirteenth and fourteenth months of the illness, the following notes were recorded: . . . the girdle sensation is diminished and at times absent. The patellar reflex is at times normal, at times exaggerated; the diaphragmatic reflex is sometimes present, sometimes absent. . . ."

to deserve publication, or even trial, without verification by others, but have been guides or helps to me in curing the sick, and are culled from memoranda made in my visiting-book. It is so easy to be mistaken, and so important or serious a matter to make a positive statement or recommendation of a remedy, lest another should be misled, that these remarks are given for what they may appear to be worth. I, as a rule, employ higher preparations in my practice, but because the following were odd or new remedies not in the regular list, they were prepared in my office and run up on the decimal scale with distilled water. I usually worked on one medicine for several days or weeks, giving it to a great variety of persons, and have been anxious to get only a few symptoms which might be relied on.

*Iodo-Hydrargyrate of Potassium*— $(2KI.HgI_2).3H_2O$ , Mercuric Potassium Iodide.—30th decimal, using as a base three and a half grains of iodide of potassium, dissolved in an ounce of water, to which is added four and a half grains of the red iodide of mercury (described on page 1831, last edition, *U. S. Dispensatory*). The medicine was given in water, one teaspoonful every hour or two hours—twelve to fifteen doses daily. About the third day and later, the most constant symptom noticed was soreness of the throat, tonsils and pharynx, with more or less hoarseness. There was a disposition to raise saliva or spit a good deal, loss of appetite, white-coated tongue, very disagreeable taste in the mouth, and continuous but not great heat of skin. There was no tendency to chill or sweat. The less important symptoms (and not present in the majority of cases) were aching and soreness in the muscles, usually of the lower extremities; weakness; conjunctiva and nasal mucous membrane somewhat irritated; headache, or external soreness in the frontal region; urine dark, clear, but diminished in quantity. A few of the cases had rough, itchy skin, with small, very red papillæ scattered over the body. Other and important symptoms, no doubt, were not recorded. It is the best general remedy known to the writer for chronic syphilitic bone or muscular pains, sore white patches or ulcerations in the mouth, and the papular eruption of specific disease. The constant headaches due to syphilis, and a form of headache which leaves the periosteum and scalp sensitive, especially in the frontal region, have been helped quickly and permanently by this remedy. It has no curative effect on the usual sick or congestive headache which affects the eyes. The results, with the few cases of diphtheria treated by this soluble form of iodine and mercury, have led to the greatest confidence in it, especially in grave cases, where the disease has



poisoned the whole system, and the exudation exists on the trachea and larynx. To those who have no faith in dynamized medicines, I would suggest ten to fifteen drops of the original solution put in three times that number of teaspoonfuls of water, and a teaspoonful given internally every hour until marked improvement sets in. Pellets in solution may be given oftener, say every half hour.

Malignant scarlet fever, with very severe throat and nasal symptoms, enlarged cervical glands, inability to swallow well, partly or wholly stupid condition, imperfect rash, and continuous very high temperature, has been apparently assisted towards safe and sure recovery in a comparatively short time. It has a marked curative action in chronic conjunctivitis, persistent sore throat, enlarged tonsils, and nasal catarrh attended with crusts and bad odor. The genius of the remedy and the disease must correspond. A prover knows something of this, which is difficult to describe, and therefore an apology for this crude generalization.

*Antipyrine, 30th Decimal.*—Given frequently in water has, after several days, been followed by a red, flushed face; congestive headache, somewhat like that caused by belladonna, with the addition of sharp, electric-like or neuralgic pains in the forehead and face; some nausea; general heat of skin, with much itching, particularly about the chest. There is a great disposition to scratch.

Clinically, and in a potentized form, it has no such power as acornite in the reduction of temperature, and is not attended with so much perspiration as that remedy. Two cases of severe chronic facial neuralgia of the third branch of the fifth pair were cured after giving it for several days.

Both had itchy, red blotches about the face and neck, which disappeared with the pain. Several times the severe or acute pain of rheumatic arthritis was quickly relieved with it when other well-known and usual remedies did no good. It had, however, no curative action on the disease proper. Patients, as a rule, sleep better after taking it. Its action in relieving certain forms of congestive headaches, to which it bears a resemblance, is uncertain and disappointing, and much inferior to belladonna.

*Strophanthus Kombe, 30th.*—Skin cold and moist; no fever; sleep light, and broken with vivid, frightening dreams; tongue coated; mouth and throat dry; complete loss of appetite; no thirst; restlessness of body; breathing short, oppressed and attended with much movement of the abdominal muscles; constriction about the left chest in the region of the heart; pulse slower by a few beats;

bowels, which had been constipated, became loose; urine greatly increased in quantity, nearly doubled in amount; all the symptoms worse at night, and while lying down. This remedy has been of great service in palpitation from indigestion and tobacco; in relieving cases of heart pang, whether from organic or functional trouble.

Its marked effect is best seen in Bright's disease, attended with general dropsy and greatly diminished secretion of urine. Its good effect, by increasing the amount of urine, is often noticed in a few hours, but, unfortunately, in the few cases studied it has only been palliative, and its action for good ceases in a few days. After its use, the usual intervals between the times of aspirating the chest have been lengthened for awhile.

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#### THE WORK OF REVISION BY DR. CONRAD WESSELHÖFT—A CRITICAL ANALYSIS.

BY THE MEDICAL INVESTIGATION CLUB, OF BALTIMORE., MD.

IN the *HAHNEMANNIAN MONTHLY*, March, 1890, is published an article on "The Work of Revision by the Medical Investigation Club, of Baltimore—A Critical Analysis," by C. Wesselhöft, M.D., which contains statements so unjust and misleading that we are compelled to answer it at some length.

In reviewing the many assertions therein contained we are dismayed at the apparent enormity of our offences! Plagiarism, deceit, ignorance, ridicule, unfairness, arbitrariness, monopolization! To the superficial reader it may appear that Dr. Wesselhöft has practically buried us in our iniquity. We hope, however, that the readers of the article in question have postponed judgment until they have heard our vindication.

Dr. Wesselhöft says: "It was to be hoped and expected that these initiatory articles\* would create an interest in a subject which had lain dormant since the beginning of homœopathy, namely, the investigation of the real value of an enormous accumulation of material in the form of provings."

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\* See *New England Medical Gazette*, June, 1886, December, 1888, January, 1889.

Is this statement in accord with well-known facts?

We grant that a basis of drug revision was distinctly suggested by Dr. Wesselhœft in 1886. But let us bear in mind that for many years previous the subject of the impurities in our *materia medica* and of drug revision had been agitated by many prominent writers, notably Drs. J. P. Dake and Richard Hughes, and many minds were pondering thereon. In support of this, witness the following quotations:

"It was intended first of all to draw out the views of leading thinkers and workers on *materia medica* as to the feasibility of abbreviating or condensing our display of drug effects. . . . In the next place it was intended to draw out illustrations of different methods of culling from our vast display of symptoms the characteristic and most important."—(Explanation of circular to members of the Bureau of *Materia Medica*, J. P. Dake, Chairman, *Institute Report*, 1883).

"It is now some two years ago that the British Society passed a series of resolutions. The first one reads as follows: 'That in view of the considerations as to the state of our *materia medica*, lately introduced by Drs. Yeldham and Black in this country, and Dr. J. P. Dake in America, the British Homœopathic Society feels that the time has come for its reconstruction, and is prepared to undertake the work.' The other one is as follows: 'That the aim of the committee shall be to expunge all untrustworthy and irrelevant matter, and to present what remains in the most accurate, concise and intelligible form.'—(Remarks by Dr. Hughes, *Transactions American Institute of Homœopathy*, 1884).

The first fruit of this movement was the *Cyclopædia of Drug Pathogenesis*.

For the purpose of establishing a point in the history of the drug-revision movement we will call attention to the following facts: In the *North American Journal of Homœopathy* for August, 1883, is an article entitled "*Cæsium*," the author of which was at that time, and is now, a member of the Medical Investigation Club. Although at the time the proving of the drug *cæsium* was not officially the work of the club, yet, besides the author, three other members of the club assisted in making the provings. This paper contains, substantially, the method of "critical analysis" and the "synthetic method," both practically applied to *materia medica* revision. We herewith make a few quotations from this study, which we compare with Dr. Wesselhœft's *cactus* and *hyoscyamus*, viz.:

## EXTRACTS FROM CÆSIUM.

*Head.*—"Five provers had headache in various forms. The frontal region was affected in two; the temporal in two; a drawing sensation was experienced by two provers, etc."

*Pharynx.*—"Four provers had soreness in the pharynx. . . . In two the soreness was worse after sleeping."

*Abdominal Effects.*—"Two provers had diarrhœic stools, one of whose dejections were 'bilious,' and the others were small and odorless."

## EXTRACTS FROM CACTUS.

*Head.*—"Here we discover that in head symptoms the predominant pain is one of pressure, which occurs five times in Rubini's list. Besides there is the usual kind of sensations, such as 'emptiness,' 'pulsating,' 'tension,' found in every proving."

*Throat.*—"The throat symptoms, though represented by two provers only, are significant; violent sticking and dryness."

*Abdominal Effects.*—"There (provers of tr. and fl. ext., except No. 6) we find recorded flatus and griping from flatus, described by two others as sticking and cutting."

These extracts from "Cæsium" are as distinctively composite or "synthetic" as any of the symptomatologies published since 1886. Even early in 1888, Dr. Wesselhœft evidently had no intention of basing his claim of priority on the June, 1886, article, as we find in his report of the Committee on Pharmacy, American Institute of Homœopathy, 1888, he says: "To separate the wheat from the chaff is necessary, but no one has pointed out the way."

Although "literary usage is explicit and inexorable on this point," yet we still hold that the question of priority is irrelevant to the point at issue; but we wish to emphasize the fact that it is this proving of cæsium which is the foundation of the synthetic method of the Medical Investigation Club. We wish also to call the attention of our censorious critic in the *North American Journal of Homœopathy* to the contrast between the above point of history, and his assertion, "the scheme of the Baltimore Club is essentially that of Dr. Wesselhœft's; is based upon his plan." We merely wish to remark that he has made a mistake.

The imputation of our dishonesty of purpose and previous acquaintance with Dr. Wesselhœft's work, from which it is intimated we deduced our plan, and by means of a little dressing, foisted it on the profession as *original*, is unworthy the source from which it proceeds. The attention of the Medical Investigation Club was first called to the work of Drs. Wesselhœft and Sutherland, published in the *N. E. Med. Gazette*, for December, 1888, some time during the winter or early spring of 1889, and our first feeling was one of surprise that others were working in such close lines to ours. As soon as we were apprised of the fact that Dr. Wesselhœft had instituted and published a working method for drug revision, we considered it

due him that he be notified of what we were doing, and thus at the start avoid all possibility of future misunderstandings. A letter was therefore sent to Dr. Wesselhœft, bearing date April 12th, 1889, from which we extract the following :

" We have observed that you, in connection with a number of others, are engaged in studying drug provings according to a new method. We are very much interested in such work, and think it but courteous to advise you of the fact that for the past two winters the Medical Investigation Club, of Baltimore, has been engaged in preparing a *materia medica* based upon a strictly scientific method, the details of which are in part somewhat similar to your plan. Our initiatory volume, comprising twenty-one drugs, is now about ready for the press.\* To prevent any suspicion, therefore, that we have copied or borrowed any part of your method, or that we have only worked from the hints you have given in the journals, we desire to state that our first drug was *completed* early in March, 1888, and our attention was not called to your idea until after reading your article published in the July, 1888, number of the *HAHNEMANNIAN MONTHLY*, by which date six of our drugs had been completed ; your detailed plan of work was not published until December of 1888, when it appeared in the *N. E. Med. Gazette*, and which has in no wise modified our method. We think it only just to ourselves and you, to thus frankly acquaint you with what we have done, before our effort is finally submitted to the medical profession ; and we trust that you will accept this pledge of our confidence and respect in the same spirit in which we tender it."

How this letter may have impressed Dr. Wesselhœft we do not know, as we have received no answer from him to this date.

About this time several samples of our work were submitted to Otis Clapp & Son, of Boston, for opinions relative to ultimate publication. In the meantime we concluded to send the drug *bryonia*,† with a few introductory remarks, to some journal for publication. The *HAHNEMANNIAN MONTHLY* was selected, and the paper sent. We quote from the editors' letter of acceptance :

" Your valuable paper has been duly received. We regret that it was not sent earlier, especially as it is important that it shall appear in our June number. We had already completed the make-up of that number somewhat earlier than usual, but your paper is of so valuable a character, that we shall, in order to make room for it in the June number, make that issue of extra size."

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\* Since then we have changed our plans for publishing.

† Published in the *HAHNEMANNIAN MONTHLY*, June, 1889.

In the same mail with their acceptance, came a letter from Dr. J. P. Sutherland, editor of the *N. E. Med. Gazette*, dated May 15, 1889, extracts from which we herewith subjoin :

"I should be greatly pleased to have a paper from you—your study of ant. tart. for instance, for publication in the *Gazette*. As you know, the thorough and scientific establishment of our *materia medica*, is one of the *Gazette's* hobbies, and anything looking in that direction is especially welcome. Dr. J. W. Clapp has told me of the work you have in hand, and has been kind enough to let me see your papers. The comprehensiveness of your plan, its practical and thoroughly sound nature, lead me to offer the following suggestion, which I trust may be pardoned on the score of my great interest in the subject; test the profession by publishing a brief explanation and example of your plan. A paper in one of the June periodicals will bring it before the profession before the Institute's meeting, and the pages of the *Gazette* are open to you for the purpose. . . . I trust you will understand that my motive in offering this suggestion is simply an interest in our common cause, which I know to be dear to the hearts of many earnest workers. And as the *Gazette* has recently made public Dr. Wesselhœft's plan of revising our *materia medica*, it seems eminently fitting that it should be the medium of presenting your plan to the profession."

Evidently to Dr. Sutherland (who, it should be borne in mind, was Dr. Wesselhœft's collaborator in preparing the drugs by which his plan was elucidated), our work bore the impress of both "novelty and originality;" and we leave our readers to judge whether or not the editors of the *HAHNEMANNIAN MONTHLY* and the *N. E. Medical Gazette* would have accepted an article so manifestly unoriginal as Dr. Wesselhœft would make believe. But, as Dr. Wesselhœft remarks, "the question of priority being set at rest," and also our honor vindicated, let us turn our attention to the *real* question, "as to whether the 'new and scientific' or 'synthetic' method differs or is superior to the one termed 'analytical.'" That it differs materially, manifestly and vitally, we will presently show. Whether or not it is *superior* is a question which *we* were willing to leave to the verdict of the profession. The following is a definition of synthesis as given by Worcester: "The deduction of general conclusions or principles from the putting together of particular facts or instances. The opposite of analysis." "*Synthetic method: the deductive method.*" Synthesis, therefore, implies that an analysis has either been made previously, or that the component parts were already arranged awaiting synthesis. That Dr. Wesselhœft does not consider the act of classi-

ifying a proving into a schematic form as being any part of analysis is evident, when he remarks:

"Allen's work, containing records of all provings, constitutes the safest *basis* for *analyses* for general publication, aside from the convenience of its arrangement, which in the use of Dr. Hughes's work has *first to be made before comparisons* (analyses) *are undertaken*."

Therefore, our preliminary work of arranging a proving into a schematic form is *not analysis*. Once in this form, a *critical synthesis commences*; and that our method of consecutive groupings is properly called a "synthetic method" from the first classification to the final deduction, it is folly to deny. And only a very superficial reading could explain, Dr. Wesselhœft having overlooked our full description and illustration of our plan of work, as given in the September, 1889, *HAHNEMANNIAN* (pages 551-554), where also the manner of obtaining and applying the exponent may be found, and "what its real or possible value is."

It is not our purpose here to enter into the question of high potencies; but in view of the previous expressions of Dr. Wesselhœft on purity of provings, and the valuelessness of high potencies, we are surprised at his present position. We quote a few extracts from Dr. Wesselhœft:

"Recounting the sources of possible and probable error, there are: First, inaccuracies of proving resulting from perfectly unmedicinal preparations, such as the pellets moistened with a dilution of a practically insoluble metal, or a soluble substance diluted beyond the limits of matter. . . . Attempting to dilute an undilutable substance, thousands of endless spaces beyond what is usually spoken of as endless space, will never make something out of nothing. . . . Then study existing provings according to this standard; that is, select from voluminous provings those which have been made with reliable preparations of drugs, excluding those which have not been made in this way."\* "He was convinced that no healthy person experienced effects from refined or highly attenuated drugs."†

His position here is unmistakable. Let us see with what he is now *identified*:

"In order to accomplish our (present!) purpose we should aim at

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\* "On the Evidence of the Efficacy of Therapeutic Methods."—*HAHNEMANNIAN MONTHLY*, July, 1888.

† Report of the Committee on Pharmacy of American Institute.—*North American Journal of Homœopathy*, July, 1888.

the introduction of a method which shall make no invidious distinctions between, nor admit any *a priori* assumption as to the validity of provings. . . . It has not to determine whether the drugs used were properly prepared or what their nature was; it has little to do with the health or temperament of provers.”\*

And Dr. Allen says:

“I would . . . . exclude no experiment from examination which appears to have been made in good faith; we should criticise equally provings by the c.m. and by the tincture.”† “All experiments, the details of which have been fully recorded, are to be submitted to a critical examination; these include provings made with all sorts of doses, in both high and low dilutions.‡

No exception is anywhere taken to fluxion potencies nor clinical symptoms.

If Dr. Wesselhœft expects thus to “determine this mooted question” of potency, we wish him success; but until this is assured beyond question, we decline to expend our energies upon this extra amount of “chaff.” The same reasons which influenced the American Institute Committee to agree with Dr. Wesselhœft’s demonstration of the 12th dec. as the probable limit of subdivision, hold good to-day, and cannot be better stated than by Dr. Hughes:

“I do not disclaim any proving above the 12th (dec.), but my feeling is that a line of separation here would be best received by the profession in England, and I was assured that it is the same in this country. Those who believe in the efficacy of high potencies can still receive and study the effects of drugs in more tangible form, which are acceptable to the vast majority of our school, and I think that more harm would be done by offending these than by disappointing those.”§

In further support of our decision adopting the *Cyclopædia of Drug Pathogeneity*, in preference to other authorities, as the basis for drug revision, we again adduce eminent authority:

“Existing publications, such as Jahr’s *Manual* and Allen’s *Encyclopædia* did not furnish the positive or pure effects of drugs on the

\* “Critical Analysis of Drug Provings,” Drs. Wesselhœft and J. P. Sutherland.—*N. E. Med. Gazette*, December, 1889.

† Report of Meeting of N. Y. Mat. Med. Committees with Drs. Wesselhœft and Sutherland.—*North American Journal of Homœopathy*, April, 1889.

‡ “A New Materia Medica.”—*North American Journal of Homœopathy*, June, 1889.

§ *Transactions American Institute*, 1884.



healthy, aside from and unmixed with those observed in the sick while more or less under drug influence.”—(J. P. Dake, “Scope and Progress of the *Cyclopædia*.”—*HAHNEMANNIAN MONTHLY*, July, 1888).

“This (the *Cyclopædia of Drug Pathogenesis*) is the only work at present accessible to every one that shows clearly the physiological action of the drug. It is impossible to construct a physiological drug pathogenesis that shall correspond to actual facts and demonstrable proofs from any other work.”—(Vandenberg, Chairman of Bureau of Materia Medica, New York State Society, *HAHNEMANNIAN MONTHLY*, November, 1888).

“The *Cyclopædia of Drug Pathogenesis*, without doubt the first and prime essential of a complete materia medica, the mine out of which must be dug the materials of all future materia medicas; and unless this has been taken as the foundation, no treatise on materia medica should in future be considered worthy of acceptance.”—(Hayward, “The Materia Medica of the Future,” *North American Journal of Homeopathy*, September, 1889).

“The mode in which the *Cyclopædia* presents the subject of drug action is the scientific and natural mode, and must constitute the basis of any perfect knowledge of drug effects that we can ever hope to attain.”—(Editorial, *HAHNEMANNIAN MONTHLY*, January, 1887).

We admit, that if we are to include “provings made with all sorts of doses, in both high and low dilutions,” “the c.m. equally with the tincture,” “whether or not the drugs used are properly prepared, or what their nature was,” the *Cyclopædia of Drug Pathogenesis* is not the proper basis; and we are in full accord with the sentiments so pointedly expressed by Dr. Hughes:

“No one can appreciate better than myself the industry, zeal and devotion displayed in the work issued by my friend Dr. Allen . . . but its claim to finality rests on the assumption that the materials collected together therein are good, and that the mode of presentation is also satisfactory. This assumption I cannot support. I value the work as the summing up of all that has been done in the past of its kind and in its manner, but not as providing for the future.”\*

We regret that our efforts at differentiation should have been construed as ridicule; nothing was farther from our intention. But when Dr. Wesselhoft kindly gives permission to “those who cannot accept from what is generally called ‘tact,’ ‘policy,’ or ‘conviction,’ the simple conclusions expressed herein . . . to formulate better rules;” and “to each to find his own technical method,” we certainly feel at

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\* *Transactions American Institute*, 1884.

liberty to express our "conviction," based on much study, that the purest pathogenesis obtainable is the one from which to expect accurate results, and that our method of arriving at the final conclusions is both logical and more expeditious.

Especially are we the more convinced of this when Dr. Wesselhøft says of his own method: "*As the chairman could not bring himself to do the work on so gigantic a scale*, he selected eleven provings of hyos. out of the ninety-six recorded, to furnish a fair example and illustration of the methods proposed to be pursued in future."\* Also the first compiler publishing under this illustration (Dr. O'Connor), says:

"The chief objection to the chart plan is the great expenditure of time and trouble to no purpose, in pasting, laying out the chart. . . . Another objection is that the paucity of symptoms in some provers demands just as much room on the chart as the long record of more susceptible or more fanciful persons, and thus the size is greatly increased, and the chart becomes practically unmanageable. . . . In conclusion, it seems to me that the results to be gained from the charts should be reached and could be reached by some better method."†

With this conclusion we agree; and in our December articles merely intended to call attention to the "individual characteristics" of the two plans and wherein they differed, having, we thought, sufficiently elucidated our plan in the September HAHNEMANNIAN.

Dr. Wesselhøft states that "to emphasize the impression intended concerning the absurdity of our humble efforts . . . the statement No. 4 (HAHNEMANNIAN MONTHLY, December, 1889, p. 755) is a conspicuous distortion of the rule which calls for numerous tests." Now we submit, that if we "accept those effects only which are corroborated by numerous tests, of which there should be no less than three," and that "these three provings should be by different provers,"‡ we are perfectly correct in our statement No. 4, that "only symptoms which have been experienced by three or more different provers are to be used" (preserved), and that the construction placed upon it is both unjust and unprovoked. We quote the opinions and interpretations of this rule by several others:

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\* "Critical Analysis of Drug Provings."—*N. E. Medical Gazette*, December, 1888. *Italics ours.*

† *North American Journal of Homœopathy*, June, 1889.—Analysis of Gelsemium.

‡ "Critical Analysis of Drug Provings."—*N. E. Medical Gazette*, December, 1888.

"Rules, Suggestions, Etc."—*North American Journal of Homœopathy*, December, 1888.—HAHNEMANNIAN MONTHLY, December, 1888.

"Symptoms are not to be accepted as positive unless corroborated by about 25 per cent. of all the observations. At least two observers out of seven should agree, and if the number of observations be larger, an even larger per cent. ought to be required.—(Dr. Allen, "A New Materia Medica," *North American Journal of Homœopathy*, June, 1889).

"It was moved that 'those symptoms shall be preserved in which there is an agreement of approximately 25 per cent. of the observers recording effects on the anatomical group.' Carried."—"Revision of the Materia Medica," *North American Journal of Homœopathy*, April, 1889).

"Summary of symptoms found in 8 per cent., that is three or more of the thirty-four provers of Gelsem., as in Allen's *Encyclopædia*."—(O'Connor, *North American Journal of Homœopathy*, June, 1889).

"According to our rule, to require congruence among 25 per cent. of the observers in any one caption, four provers have agreed upon congruence among 25 per cent. of the observers in any one caption, four each in the mind. . . . In the remaining twelve captions symptoms have been preserved in the summary by congruence in two provings"—as in our work—(Moffat, *North American Journal of Homœopathy*, November, 1889); and we presume Drs. Pearsall and Porter retain symptoms congruent in 8 per cent., i.e., two out of the twenty-five provings mentioned.

Here we find Dr. Allen first suggesting the retaining of symptoms "corroborated by about 25 per cent.;" next, "25 per cent. of the observers recording effects on the anatomical group." Dr. O'Connor preserves congruent symptoms found in 8 per cent.; Drs. Porter and Pearsall, 8 per cent.; and Dr. Moffat "25 per cent in any one caption." Hence, we doubt not that the rules of percentage adopted by Dr. Wesselhœft and his co-workers are "temporary and tentative;" in other words, experimentive; but on this question we long since passed the experimentive stage. By adopting the exponent placed as illustrated in the Baltimore club's work, preserving congruent symptoms occurring in two provers, and bearing in mind the number of provings on which the symptomatology is constructed, not only are many more symptoms retained for future corroboration, but the reader may adopt any percentage his "convictions" may dictate. Its *usefulness* Dr. Wesselhœft is compelled to admit.

The only suggestions we can find of the "principle of denoting corroborations" are in the remark of Dr. Allen: "I would accept a definite symptom observed in two different provers—at least for a tentative report—and note how many times it has been observed (Revis. of Mat. Med., *North American Journal of Homœopathy*, June,

1889); and the form in which "Comparisons of Pathological Value" are presented in cactus and hyos. (*N. E. Med. Gazette*, December, 1888). This is also found in cæsium. Certainly in Dr. Wesselhœft's illustration, the schema to which the general practitioner would more naturally turn for a ready answer, is silent.

While we do not admit having claimed novelty in originating the exponent as indicative of values, we may justly claim "recentness of introduction" in its application to this work for this particular purpose; we have sustained our claim of the originality of our plan of work, in that it was conceived and perfected in total ignorance of the existence of Dr. Wesselhœft's plan; as has been shown, "our synthetic arrangement" is fully explained, a fact unaccountably mis-stated by Dr. Wesselhœft. If Dr. Wesselhœft "is endeavoring to gain co-operation in a new and laborious method of investigating provings," the tone of his article is hardly calculated to enlist the sympathies or assistance of the Baltimore club, even were we not convinced that the "flagrant fault" of Dr. Wesselhœft's method is the admission of "provings made with all sorts of doses, both high and low;" "criticising equally provings by the c.m. and by the  $\phi$ ;" "excluding no experiment which appears to have been made in good faith," and in "having not to determine whether the drugs used were properly prepared or what their nature was." Certainly while these ideas obtain, it is impossible for us to co-operate.

In conclusion we wish to assure Dr. Wesselhœft, that we have no intention to misrepresent or undervalue his work, but on the contrary we appreciate the value of all he has done, and wish that all workers in this field were as well qualified; and further, because the Medical Investigation Club has adopted certain rules and regulations, which are at variance with the opinions of Dr. Wesselhœft, we see no reason why either method should be substituted for the other, nor is it necessary that the two methods should be merged into one with the distinctive features of one or both distorted into a false harmony; but let both plans be pursued to a legitimate termination. Neither do we see reason for jealousy or ill-feeling of any kind; if anything we have written has been or could be construed into such meaning, it is through a misunderstanding on the part of our critics, and we disclaim any but the most pacific intentions, and so strongly are we opposed to a war of words, that unless unforeseen necessity occurs, we intend this to be our final controversial effort on the subject of drug revision. At the same time, we will hospitably entertain "*friendly* comment and criticism," and endeavor to profit thereby.

## RADICAL CURE OF HYDROCELE BY ELECTRICITY.

BY L. W. READING, M.D., PHILADELPHIA.

IN presenting this paper to the medical profession I do not wish to assume the position of recommending the routine use of one agent or procedure to the exclusion of other rational remedies in the medical or surgical treatment of any one class of disease, but merely to show that we have in the chemical effect of the galvanic current brought to a focus on the bared surface of the negative, or negative and positive poles together, a quick, easy and effective remedy for hydrocele.

All that is necessary in the way of an apparatus, for the successful treatment, is as follows :

1. A good working battery giving a current strength of twenty-five mille-amperes, although I have rarely found it necessary to employ so strong a current. 2. A mille-ampere meter to measure the current, as without this no one can use electricity intelligently. 3. A current controller which enables one to increase or decrease the current without interruption or shock to the patient. 4. A disk electrode, about two inches in diameter, properly covered with absorbent cotton, about three gilt steel needles properly insulated to within one-quarter of an inch of the tip, and a sufficient number of conducting cords.

Although the introduction of the needle is not very painful if done by a quick rotary movement, the same as introducing the trocar for tapping, yet I have found it necessary to employ, particularly in nervous, sensitive subjects, an injection of cocaine at the point where I intend making puncture. Care should be taken that the points of the needles should project into the fluid, as, if they merely pass into the subcutaneous cellular tissue, or the tunica dartos, the current would only act upon these membranes, but not upon the liquid accumulated in the sac of the tunica vaginalis. If we are using two needles attached to different poles, they should be introduced at opposite sides and so deep that the points merely approach each other. When the sac is very large and we wish to act on the fluid and membrane very thoroughly at one treatment, we can introduce two or even three needles and attach them to the negative pole. I usually employ but one pole and one needle within the sac, and rarely have I found it necessary to use two. I always give the preference to the negative as the active pole on account of its greater power in electro-

lysis, and use the positive as the non-active pole on the groin or thigh of the same side.

Some writers have advised evacuation of the sac before treatment, but I very seldom disturb the sac, believing we can act on the lining membrane more thoroughly and equally with the fluid remaining enclosed.

The application should be made from five to fifteen minutes. Sometimes one application is all that is necessary, but it usually requires two or three.

The great end to be accomplished is not the withdrawing of the fluid, which can be done by the trocar and canula, but its decomposition or altering of its contents and the stimulation of the membrane of the sac, so that absorption shall take place and the fluid not again collect. From a misapprehension of this fact many failures have occurred in the treatment of hydrocele.

The following cases may be related in detail as illustrative of the manner and result of treatment:

CASE I.—J. D., *set.* 58 years, came to me for treatment, July 25, 1889. He had been troubled for two years with enlargement of testicle and hydrocele of right side, the result of falling straddle on a fence rail. The sac had been emptied twice by tapping, but filled again in a short time. Examination showed hydrocele of right side of scrotum. Sac containing about fifteen ounces of fluid, and testicle enlarged about one-half its original size, and pressed backward and upward. After an injection of cocaine to lessen sensibility of the parts, I introduced a three-inch gilt steel-needle, insulated to within one-quarter of an inch of the tip, into the sac, about the position and in the same manner as you would introduce the trocar and canula. Attaching the cord connected with the negative pole of the battery, to the needle, and completing the circuit by placing the disk electrode, connected with the positive pole of the battery, on the groin of the same side, I gradually turned on the current until I noticed by my mille-ampere meter that I had ten mille-amperes. Finding this gave no discomfort to my patient, I increased it to fourteen mille-amperes. It was allowed to pass for fifteen minutes. On withdrawing the needles no bleeding occurred, only a slight escape of fluid, and, with the exception of a slight puffiness, no change was perceptible externally.

July 27th.—He complained of headache and dragging sensation on that side of scrotum. Sac much smaller and very sensitive to touch; temperature, 99°.

August 9th.—All inflammation gone; no swelling; sac empty. Testicle still large. Advised him to wear a suspensory to support testicle.

August 20th.—No return of swelling. Patient feels better than he has for five years. Some reduction in size of testicle.

I saw this case November 27th, and, after examination, could find no trace of the disease, and with a decided reduction of size of testicle, as it was only slightly larger than the left.

CASE II.—S. E., æt. 39 years, came under treatment, November 5, 1889. He had been troubled with hydrocele of left side for ten years. The patient was unable to assign a cause for the trouble. The sac had been frequently emptied by tapping, but filled again in a few weeks. On examination, the left side of scrotum was found to offer the usual appearance of hydrocele. At a rough guess the sac might be estimated to contain twenty ounces of fluid. I felt inclined at first to draw off some of the fluid; but, on second thought, concluded to let it remain so that I might fully test the power of the electric current.

I introduced two gilt steel needles in opposite directions, and attached them to the negative and positive poles of the battery. I gradually increased the current to twenty milli-amperes and allowed it to pass for two minutes. On withdrawing the needles, considerable fluid escaped.

November 8th.—Swelling very much decreased; very little inflammation; no œdema: great relief to patient.

November 25th.—Not much improvement from the time of last visit. I introduced one needle and connected it with negative pole of battery, and placed positive electrode on inner side of thigh of the same side. Passed a current of eighteen milli-amperes for twelve minutes. On withdrawing needles, only slight escape of serum and considerable puffiness of sac. While using current, I could distinctly hear a crackling noise, evidently marking the evolution of hydrogen.

November 27th.—Sac much smaller, very sore and painful when touched.

December 8th.—No inflammation and no swelling.

January 12th, 1890.—Examination shows sac empty, and appearance of scrotum normal.

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### A CASE OF SNAKE-BITE.

BY JAMES HARWOOD CLOSSON, M.D., GERMANTOWN, PHILA.

THE popular opinion appears to be that snake-bites prove almost invariably fatal, and are therefore, generally, very much dreaded. In fact, the excitement of being bitten by a venomous snake is alone sufficient to cause prostration, independent of the immense strain

upon the nervous system by the endeavor to eradicate the poison by the means of caustic and by the other methods adopted to save the patient.

On August 23d, at 6 o'clock P.M., I was summoned in great haste to see Mr. J. C., who, thirty minutes prior, had been bitten in the forefinger of the right hand by a copperhead snake (*trigonocephalus contortrix*), a snake that is very uncommon in this neighborhood. Immediately he realized what had occurred he put the finger in his mouth and kept sucking it for quite awhile, occasionally taking full doses of whisky, while those about him at once set about procuring medical assistance.

I saw him about half an hour after the receipt of the injury, and found him suffering some pain about the heart and a slight feeling of constriction about the chest. The part bitten was considerably swollen by exudation and by the extravasation of blood, and was also painful, both pain and swelling slightly extending up the arm toward the body. There was some headache, and marked symptoms of shock soon were made manifest; fainty feeling; giddiness and vertigo; clammy sweats; slight nausea; and particularly great terror, with a feeling of intense weakness.

I also found his body bedewed with a cold perspiration; his pulse rapid and fluttering. There was quite a decided disinclination to speak or answer questions. Pretty free bleeding had occurred, which was encouraged by the sucking of the finger by the mouth, the immediate effect of which seemed to be the modification of the pain and of the constriction. The patient was evidently pretty thoroughly poisoned, and an effort was therefore made to bring the system rapidly under the influence of whisky; in other words, to make the patient as drunk as possible and as soon as possible, maintaining this effect for some time in order to keep the vascular and nervous system stimulated to the activity required to effect elimination. When I first saw him he had already drunk eight ounces of whisky, to which he was unaccustomed, without any evidence of intoxication. This agent was therefore repeated in ounce doses every ten minutes until twenty-four ounces had been taken.

Both fangs of the snake had penetrated the skin, and the wounds thus made, and the parts around, were freely scarified. They were then freely bathed in warm water in order that bleeding might be encouraged; and they were finally thoroughly cauterized by the use of carbolic acid, after which fomentations of saleratus were applied. In conjunction with this method of treatment, I should also men-



tion, probably, the internal administration of half-teaspoonful doses of ammonia in a wineglassful of water every fifteen minutes.

After these measures had been adopted for a few hours, and especially after the administration of the ammonia, the patient appeared to revive, and the pulse, which had risen to 96, fell to 82; in fact, he continued to do so well that in eight hours from the time of my visit I felt safe in considering him completely out of danger. The hand, of course, remained in a bad condition for a long time, the wounds in the finger being kept open and allowed to bleed as much as possible, but was eventually healed. A condition of debility afterward ensued, for which he received china, and egg and whisky were administered every three hours, the case terminating favorably in ten days.

In this case I believe a life was saved by the propping up of the depressed powers by the use of diffusible stimulation until the shock, always, I believe, an attendant of snake-bites, was recovered from. The ammonia, diluted just sufficiently to enable the patient to swallow it, and freely administered, proved an efficient remedy. The benefit derived from the application of the saleratus depended, I believe, in a great degree, upon its almost immediate application.

It may be questioned by some as to whether this was really the bite of the copperhead; but as the snake was seen, and several young snakes of this species had been killed on the place, there can be but little doubt arise as to the identity. At all events, the patient was extremely ill, but made a good recovery under the treatment above described.

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## UNTIMELY THOUGHTS.

BY GEORGE B. PECK, A.M., M.D., PROVIDENCE, R. I.

(Arranged from an Uncalled-for Speech.)

THERE is a medical school mine eyes have never seen. Its *picture* is fair to look upon. Its faculty is proud thereof, also its alumni; so, too, am I. Its students publish a spicy sheet, most creditable to their culture and literary ability. Occasionally, however, an indefensible article appears therein. A paper on "Ergot, and the Indications for Its Use," which would be entitled to the highest com-

mendation, had it appeared in almost any allopathic periodical, simply disgraces a homœopathic magazine, after Mundé has warned the world to "Beware of ergot," and Garrigues has said "I never use ergot until after the expulsion of the placenta." Yet, students are not singular in their blunders; grave seniors sometimes bear them company. I was amazed at a recent meeting of the Rhode Island Homœopathic Society, to hear an ex-president, a man who has raised himself to influence and fortune by his unaided effort, a physician whose prescriptions are ordinarily thoroughly homœopathic, and a diagnostician said never to be caught tripping, affirm that, as intermittent fever had been demonstrated to be due to the presence of a certain bacillus, its only possible treatment is to administer the appropriate germicide in sufficient quantity to kill the microbe. He forgot for the moment that before a quarter part of the required amount could be administered, the patient himself would be defunct! That student can justly plead youth and inexperience in extenuation of his fault; I will offer no excuse for the physician; it might be repudiated. It was his place to know and to *keep in mind* the existence of a law of cure which renders impossible the truth of any antagonistic inconsistent theory, and it is worse than useless for us, who abide in its light, to waste our time and energies in testing current vagaries. Let those, still groping in primordial *Æsculapian* darkness, amuse themselves thus if they wish; the result of their labors will be, as it ever has been,—naught. Rest assured, the venerable gentleman's statement was at once controverted, the more vigorously, because of its exalted source. The higher the authority that falls into error, the more imperative the duty of exposing the mistake, for correspondingly great will be the consequent disaster, should the declaration remain unchallenged.

Careful observation of men, their acts, and their words for a score of years, has convinced me that nothing is half so essential to a proper preparation for the medical profession as a thorough course in mathematics. It is said that soon after President Lincoln commenced his law studies, a disturbance occurred in the neighborhood for which a certain man, upon the testimony of three or four witnesses, was convicted and punished. "Why should he be punished on their statement?" said young Abe; "I can bring forward twenty men who were in the crowd that will swear they did not see him do it. Why should the word of three men outweigh that of twenty?" He determined to ascertain at once what constitutes proof and returned home to devote himself to geometry. Too many doctors

have not the faintest conception of what that word means. A gentleman once rose in the American Pædological Society, and promised to demonstrate the truth of the proposition under discussion by an incident in his own experience. When his tale was finished, he had not adduced an iota of additional evidence. The fallacy in his argument was so glaring, a high-school scholar would be plucked, who should fail to detect it. And yet this is not a singular instance. The fault is obnoxious, scarcely less in permanent than in periodical literature, in homœopathic than in allopathic writings, in surgical than in medical articles. This is the great obstacle to the progress of the healing art. A rigid mathematical training, which shall enable a youth accurately to distinguish between what he knows and what he does not know, that shall empower him instantly to discern when he has demonstrated a given position and inspire incident confidence, not only fearlessly to defend it but vigorously to assail thence the ranks of error, is the best preliminary education possible.

Recurring now to the incident first cited. Editors of our magazines conspicuously announce that they are not responsible for the opinions therein expressed. Let one of them publish a number of articles materially at variance with those wont to appear in his columns; his subscription list will speedily and emphatically demonstrate the falsity of his assumption. Some years since I was treating a case that caused me unusual perplexity. A magazine came to hand, recommending a sure method. I was not favorably impressed yet I knew not which way to turn. The writer was a stranger, the editor an acquaintance. On the strength of the latter's quasi-endorsement of his contributor, I adopted the indicated treatment. The result was unfortunate. Justly and necessarily I never again reposed confidence in anything found in that periodical, save when attested by a familiar signature. In like manner, the *editors* of that college-sheet will be held by many as responsible as its author for the appearance of the article on ergot, and consequently, to a corresponding extent, the faculty. Acquainted as I am with a number of the professors, I am not disposed, except upon further testimony, to believe that it was the result of, but rather despite of the instruction there imparted. It should teach us all, however, to be more careful in the education of our students.

Some time since, the trustees of the Fiske Fund of the Rhode Island Medical Society published a two hundred and fifty dollar prize essay on "Malaria," by Charles V. Chapin, M.D., Superintendent of Health in Providence. He mentions twenty-odd reme-

dies as possessed of particular efficacy in the treatment of that disorder, the peculiar properties of seventeen being found in our ordinary text-books. I remarked to him one day, "Doctor, your paper is excellent, your remedies entirely satisfactory, but you stopped too soon. Why did you not tell us when to administer any particular drug?" "I do not know when," was the prompt reply. Hippocrates himself would probably have given the same answer. Behold the wonderful progress of "scientific" medicine during the last twenty-three hundred years! Homœopathy alone furnishes practical indications for selection in any given case from his list of remedies. Homœopathy alone explains why one drug fails to cure and another succeeds in any given instance. Homœopathy, therefore, represents the sole improvement in medical science for more than twenty-three centuries. As it has been, so will it ever be. Hahnemann's *Organon* demands not only our confidence but our active endorsement, simply because it clearly points out the methods, the sure and only safe methods, by which the healing art can be improved, because its every teaching is in direct accord with the most advanced science of the day with its tendencies, and because it alone is based on experience with facts as they ever exist in the world we inhabit.

Hereby is clearly revealed the falsity of the statement so often made, that the two schools are rapidly approaching each other. They are as far apart as loyalty and lawlessness, as the North Pole from the South, as noonday from midnight. The one follows a working rule as closely as the education and the brains of its members will permit, the other repudiates the possibility of such a guiding principle, and threatens expulsion to any person who shall formulate one (See Code of Ethics of the American Medical Association). The one recognizes the universal supremacy of law, the other, while claiming to be a scientific body, repudiates the existence of law, without which no science can exist. Consider well the astounding spectacle! Note also how broadly he exposes himself to the charge of densest ignorance or unrivalled duplicity who claims to practice both ways. If the man knows not that it is impossible, he is a fool; if he does, he is a knave. He can no more perform the feat than be a Caucasian and a Negro. He may be an Octoroon, Quadroon, or Mulatto, but never can be a pure blood on either side. However well filled the pockets of such a fellow may be with the cash of the credulous, he receives the merited contempt of honest physicians of every name and of the intelligent laity as well.

To conclude, let us all clearly understand what homœopathy is and what it is not. Let us individually have honesty enough to acknowledge to ourselves, to our students and to our patients, when necessary, that an omission to do what others have done and are doing is the result of our own negligence or laziness or stupidity and not the failure of a law founded on the inherent constitution of matter, for frequently they will know better if we do not. Lastly, let us teach the *Organon* so that our students must adopt its principles as their own. Thus will they be enabled, building upon a rock, to work for the ages despite "the currents and counter-currents of medical belief," as evanescent as ocean's waves; thus will they be spared the mortification pertinent to the "regular" builder who can see, every semi-decade, the work of his hands engulfed in shifting sands!

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#### SUGGESTIONS FROM A CLINICAL CASE.\*

BY E. H. PRATT, A.M., M.D., LL.D., CHICAGO, ILL.

THE next case presented for your consideration, is this eight-year-old specimen of boyhood. As near as we can ascertain from the boy's father, the child was struck by a stone upon the left side of his forehead, about two years ago. The spot was swollen for a long time, but finally terminated in an abscess, which was evacuated, but did not heal. The space gradually filled with exuberant granulations to such an extent that they not only filled the sack which formerly contained the pus, but also protruded from its opening until it assumed the cauliflower appearance here presented. The firmness of the granulations indicates that they are pericranial in their origin. The tumor upon inspection, is now about an inch and a half in length, by three-quarters of an inch in width. Half of it is subcutaneous and the other half, dark-red and granular in appearance, is exposed to view. It is raised perhaps three-quarters of an inch above the level of the forehead.

Now, while one of your number is removing the growth, with the assistance of the house-physician, instead of watching him too closely, thus unnecessarily embarrassing him, let me suggest a few questions for your contemplation.

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\* A report of some remarks made in a clinical lecture.

Of the hundreds of boys who receive scalp-wounds from careless pebbles, why should most of them speedily repair the damage, without retaining a trace of the injury, while this poor little fellow has been struggling with the wound and its sequences for two long years?

When two children, of apparently equal health, are infected with scarlet-fever poison, why should one of them pass through the ordeal safely, without unpleasant complications or sequences? Why should another suffer from a subsequent nephritis, or paralysis, or other dangerous and possibly fatal local lesions?

When so many thousands of children sustain their attack of measles in the orthodox way, and come out of it unscathed, why should some poor little fellow who, perhaps, has had as good chances for a speedy relief from his affliction as any of the others, develop a septic condition so serious as to fill the pleural cavity of the left side with pus, and necessitate the performance of a capital operation to save him from a premature death, as was the case recently presented at Cook county hospital?

Why should one man recover from pneumonia, and another one develop phthisis?

In general terms, why do not all persons suffering from acute troubles brought about by the various incidents and accidents of time, recover from them in a respectable manner, instead of filling the world with an army of chronic sufferers, for whom there seems to be no adequate relief?

Leaving you to ponder upon these questions at your leisure, let me venture to predict that, in the case of the little patient before us, we shall find that some form of orificial irritation has so interfered with his general nutrition that his vitality was at so low an ebb that his poor little body had not sufficient reactive power to recover, even from a common stone-bruise. I have not examined the child, I have never seen him until the present time, know nothing of his history except the meagre account which you have already received, and that simply concerns the injury and its sequence of troubles.

Let us now make a physical examination of his lower orifices, and test the truth of my prophecy. What a foreskin! It is, at least, one-half an inch too long, an exceedingly unusual redundancy. Upon attempting its retraction, the opening is so small that it is with difficulty that I am able to expose even the point of the glans penis. As by a little continued pressure and dilatation I am able now to accomplish this, please notice the bright red, inflamed condition of

the meatus itself, and remembering what I told you about the sympathetic condition of the two extremities of any canal, imagine what a high degree of irritation must be presented by the prostatic portion of the urethra! Forcing the foreskin still further back, you will observe that its adhesion to the glans is quite extensive and firm. Loosening its attachment by the aid of a spud, I invite your attention to the unusual amount of smegma collected about the corona, and the red, inflamed condition of the parts where it is imbedded. Observe, too, that the frænum is so short as to draw the point of the glans downwards, upon extreme retraction of the foreskin. Passing my finger now into the rectum, I detect here an unusual contraction of its sphincters.

But it is necessary to proceed no farther. I simply desired to make this public test of the official philosophy and demonstrate the confidence which I feel in being able to find at these lower openings of the body a sufficient excuse for the sympathetic nerve-waste to account for the chronic condition of mal-nutrition. This child was not brought to the clinic to be circumcised, or to be treated according to official principles, and so we will not presume to do more to the case than has now been done by the skilful removal of the obnoxious frontal tumor.

Before leaving the subject of circumcision, I wish to detail for you briefly one of the cases which, some years ago, compelled me to reflect at considerable length upon the elements which a faulty foreskin played in nerve-waste, and consequently in nutritive processes. Several years ago, while in general practice, I was called upon to prescribe for a young child who seemed to be suffering from marasmus. He was exceedingly emaciated, so much so that, at the age of nine months, at which time I saw him first, he was one pound lighter than he was at three months of age. He had been a peevish, fretful child ever since his birth, and most of the time had been unable to retain what little food he could be persuaded to take into his stomach. He was an exceedingly poor sleeper, and was a constant source of anxiety to his parents. With drugs I was able to stop his habit of throwing up his food, but could not induce him to sleep well or to develop an appetite. As the child appeared to be losing ground, I called counsel. We examined the child's gums very carefully, and although there appeared to be little occasion for it, concluded to lance the incisors in hopes of relieving, to some extent, the child's nervousness. The measure, however, appeared perfectly useless. In the absence of any tangible excuse for the child's con-

dition, I seized upon the intangible and concluded that the child needed a change of air. It was accordingly taken to a healthy town in the central part of Iowa, where it received skilful treatment from first-class doctors and nurses. Three months later the parents returned home with the child, and were completely discouraged with the results of their efforts to save his life. Once more they called me to the case, and I was disappointed to find that instead of being better the child was yet weaker than when he left, and had developed anasarca of the lower-half of the body. There was no ascites, but the lower part of the abdominal walls would pit upon pressure, as also both of the lower extremities. Not knowing what else to do, I asked the mother to strip the child that I might examine its spine, and beginning with the head, I examined not only the child's spine but his entire body, as carefully and critically as I was able. I could find no fault with his anatomy, except that his foreskin did not appear to be quite normal. It was a little too long, presenting rather a small opening, and was adherent to the glans penis. I did not at that time appreciate what general mischief could result from an irritation about the glans penis, and consequently did not hail my discovery of trouble in this locality with any great degree of enthusiasm, but as everything else that I had attempted had failed to afford the child even the slightest relief, I advised the mother to permit me to simply slit open the foreskin and free it from its adhesion to the glans, having in mind simply, that if the child lived to grow up, it might prevent his masturbating. She reluctantly consented to my suggestion, but I can assure you I was not prepared for the surprise which awaited me as the result of this simple proceeding. When I visited the child the next day the mother informed me that it had slept all night for the first time in its life, and had waked in the morning with the very first manifestations of an appetite it had ever known. Cautioning her to keep the foreskin well retracted, so that it would not again adhere to the glans about the corona, I did not visit it again for about a week. Imagine my surprise upon seeing it at this time to learn that the dropsical symptoms had entirely disappeared, that the child had gained good, solid flesh, had slept every night, and was eating enough to make up for lost time. I did not examine the child locally, as he seemed to be doing so well; and I did not like to merit the young man's displeasure by any unnecessary interference with his organism. So that, greatly pleased with the result of that simple bit of work, I dismissed the case and went away



sorely puzzled at the remarkable phenomena which had been presented to me.

Two weeks later I was hurriedly summoned by the mother. As she greeted me upon my entrance into the room, I saw by the hopeless expression of her face that something terrible had happened, or was about to happen, at least in her estimation. She said: "Doctor, I thought you had better see the child once more, although I suppose now that nothing farther can be done for him and I shall lose my boy." As soon as I glanced at the child I saw at once the occasion for her alarm. It had developed an extreme hydrocephalus. The head was so enormously distended that I could place my finger in any one of the cranial sutures without coming in contact with the margins of the bones. The forehead protruded like an enormous promontory out over the face so as to distort its appearance frightfully. The head was so heavy that the child was unable to sustain its weight without assistance. In other words, dropsy had again returned, but instead of appearing in the lower part of the body, had taken the form of hydrocephalus. I asked the mother if she had kept the foreskin well retracted; she said she had, and thought there was no trouble in that region, and that it was of no use for me to look. Insisting, however, upon examination, I found the mother was mistaken. She had permitted the foreskin to again become adherent to the glans. I now circumcised the child and again freed the remaining foreskin from the glans. The consequent change for the better was not so rapid as on the previous occasion, but in two weeks the condition of hydrocephalus had entirely disappeared, and the child was once more apparently perfectly well. This was nearly ten years ago. The child has scarcely seen a sick day since, and is one of the most robust and vigorous little fellows in the city of Chicago. It was a lesson to me, teaching me how serious consequences could arise from such apparently trivial conditions.

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#### THE ALBUMINURIAS OF PREGNANCY—FOURTH PAPER.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

##### DIAGNOSIS—(*Continued*).

RECORDS of even tolerably thorough analyses of the urine during pregnancy seem to be difficult to obtain. What is wanted is a published record, in detail, of a large number of analyses from study of which to draw deductions. The quantity of urine in twenty-four hours, the ratio of the night urine to the day, the total solids ap-

proximately by Trapp's formula, or Hærer's, the amount of the solids, particularly urea and phosphoric acid, as compared with the quantity of water, the total amount of urea and that of phosphoric acid, together with the results of microscopic examination of the sediment, are the important points. Moreover, examinations of the urine of women should be made *before* marriage, as suggested by Tyson, in order to determine the average constitution of the urine *before* pregnancy. Marked changes in the character of the urine during pregnancy will then be readily noted, especially if the records are kept according to the methods suggested in my third paper.

I have made a number of analyses of the urine of women, and in some of the cases the patients have died with the usual symptoms of Bright's disease. I submit the following, which will illustrate many of the points I insist on in the diagnosis of degenerative or inflammatory conditions as opposed to those in which albuminurias are merely casual.

My analyses illustrate four classes of cases :

I. Female patients who died with the usual well-known symptoms of Bright's disease, first noticed during or after pregnancy.

II. Female patients who had convulsions, but were delivered safely.

III. Female patients either albuminuric or whose urine showed deviations from normal averages at one time or another during pregnancy, but who had no convulsions and are alive to-day.

IV. Female patients with albuminurias not traceable to pregnancy, and who are alive to-day.

CLASS I.—*Case 1.*—Female patient (married) who up to the menopause had "never had a sick day in her life," but after cessation of the monthly periods gradually grew anæmic, lost strength, had backache, became pallid, œdematous about the face, and died of uræmia.

First Analysis of Urine.		2d.	3d.	4th.	5th.	6th.	7th.	8th.
Quantity in 24 hrs.	1212 c. c.	1140	1170	1050	No rec.	840	870	600
Specific gravity.....	1014	1010	1010	1010	1010	1010	No rec.	No rec.
Total solids by Trapp's formula..	84 grammes	29	28	20	No rec.	17	No rec.	No rec.
Urea, grammes per litre .....	9	7½	8	7½	8¾	9	9½	9¾
Urea, total.....	11 grammes	8	9	7½	No rec.	7½	No rec.	5½
Albumin.....	Plenty— $\frac{1}{16}$	Plenty	Plenty	Plenty	Plenty	Plenty	Plenty	Plenty
Sediment.....	Blood-corpuscles and one granular cast found.	Tube casts Plenty.	No record.	No record.	No record.	No record.	Very little blood.	No record.

Death in six weeks from *first* analysis, and within twenty-four hours from time of *eighth*. The albumin varied from time to time, and on some days was as high as the third mark on the Esbach tube; at others as low as the first. My theory in regard to the case was that renal lesion, unnoticed at the time of pregnancy, had been present for years, the disorder running a rapid course at the menopause after the symptoms once became pronounced.

*Case 2.*—Female patient (married) became dropsical after miscarriage, and finally died of uræmia.

1st.	2d.	3d.	4th.	5th.	6th.	7th.	8th.	9th.	10th.	11th.	12th.	13th.	14th.	15th.	16th.
Quantity in 24 hrs...	750 c.c.	800	800	700	650	630	600	300	540	600	.....	.....	.....	.....	.....
Specific gravity.....	1024	1025	1028	1028	1028	1028	1023	.....	1024	1022	.....	.....	.....	.....	.....
Solids.....	35	40	45	38	36	35	27½	.....	26	26	.....	.....	.....	.....	.....
Urea, grammes per litre.....	30	28	29	28	31	32	26	34	33	24	.....	.....	.....	.....	.....
Urea, total.....	22	22	23½	19½	20	20	15	10	18	14	11	11	8	9	7
Albumin.....	⅓	.....	.....	.....	.....	.....	.....	.....	⅓	.....	.....	.....	.....	.....	.....

Sediment contains sharp-pointed uric acid crystals and a variety of casts. Blood and blood-casts absent.

Interval between first and sixteenth analysis, seven weeks. Death in less than twenty-four hours after sixteenth analysis. It will be seen that the character of the urine in this case was wholly different from that of the first. In the first case the *quality* of the urine was poor in solids, deficient as compared with the water. In the second case the solids were relatively abundant as compared with the water, but deficient in total quantity as compared with the normal standard.

*Case 3.*—Albuminuria during pregnancy. Death from exhaustion in about two months after analysis was made. Patient exceedingly dropsical; dyspnœa great.

Quantity, . . . . .	1300 c.c.
Specific gravity, . . . . .	1012
Solids, . . . . .	31 grammes.
Urea, . . . . .	13 grammes per litre.
Urea, total, . . . . .	17 grammes.
Albumin, . . . . .	⅓
Sediment: Casts and cast debris very abundant. <i>Long, straight, dark, granular casts. Large hyaline casts.</i>	

CLASS II.—*Case 1.*—Pregnancy. Analysis made about the seventh month.

	First.	Second.
Quantity, . . . . .	1416 c.c.	1020
Specific gravity, . . . . .	1020	1021
Solids, . . . . .	57 grammes.	43
Urea in 1000, . . . . .	17	15
Urea, total, . . . . .	24 grammes.	20
Albumin, . . . . .	None.	$\frac{1}{8}$ th
Sediment, . . . . .	Triple phosphate.	No casts.

Second analysis six weeks or so later than first. Urine not so good in quality. Patient delivered safely *after numerous convulsions*. Albumin did not appear until a few days before delivery.

CLASS III.—*Case 1.*—Female patient (married) became insane after confinement, and urine contained albumin. No œdema.

First Analysis.	Second.	Third.
Q'nt'y, of urine in 24 hours, . 300 c.c.	No record.	No record.
Sp. gr. . . 1030	"	"
Solids, total, . 19 grammes.	"	"
Urea, grammes per litre, . 36	"	"
Urea, total, . 11	"	"
Albumin, . $\frac{1}{10}$ ths	$\frac{1}{8}$ th	$\frac{1}{10}$ th
Sediment contains much squamous epithelium, but no casts. Some pus-corpuscles.	Pus very abundant. Oval cells plenty.	Heavy sediment of urates, and numerous very small crystals of uric acid. A few blood-corpuscles.

The third analysis was made two years later than the first. Patient alive and reported better in all respects.

*Case 2.*—Female patient. Analyses all made after seventh month in first pregnancy.

	First.	Second.	Third.
Quantity, . . . . .	930 c.c.	930	1040
Specific gravity, . . . . .	1023	1027	1023
Solids, grammes, . . . . .	43	50	48
Urea in 1000, . . . . .	14	17	17
Urea, total, . . . . .	13	16	18
Albumin, . . . . .	Trace.	None.	None.
Sediment, . . . . .	No casts.		

It will be seen from these analyses that the urine *improved* in quality from time to time. Patient alive and well. No eclampsia before, during, or after confinement.

## CASES NOT OF PREGNANCY.

CLASS IV.—*Case 1.*—Female patient (married) aged 60. No oedema. Patient suffers from paralysis agitans.

	First Analysis.	Second.
Quantity, . . . . .	650 c.c.	900
Specific gravity, . . . . .	1023	1023
Solids, grammes, . . . . .	30	31
Urea in 1000, . . . . .	24	16
Urea, total, . . . . .	16	14½
Albumin, . . . . .	⅛th	1½
Urine strongly acid.		
Sediment: Some pus "plugs," but no casts.		Pus, blood, triple phosphate, micro-organisms.

Second analysis two years after first. Patient still alive, but reported to be gradually sinking.

*Case 2.*—Female patient (married).

Quantity, . . . . .	1200 c.c.
Specific gravity, . . . . .	1013
Solids, . . . . .	31 grammes.
Urea, . . . . .	19 grammes per litre.
Urea, total, . . . . .	22 grammes.
Albumin, . . . . .	⅛th
Sediment: A few hyaline and granular casts and a few pus-corpuscles.	

This case, so far as I am aware, is still alive.

• *Case 3.*—Female patient (unmarried) convalescing from acute nephritis.

Quantity, . . . . .	1682 c.c.
Specific gravity, . . . . .	1014
Solids, . . . . .	48 grammes.
Urea in 1000, . . . . .	16
Urea, total, . . . . .	26 grammes.
Albumin, . . . . .	Trace. No casts.

*Case 4.*—Young (married) woman not pregnant, convalescing from acute nephritis.

Volume, . . . . .	1530 c.c.
Specific gravity, . . . . .	1017
Solids, . . . . .	52 grammes.
Urea in 1000, . . . . .	13
Urea, total, . . . . .	20
Phosphoric acid in 1000, . . . . .	1.41
Phosphoric acid, total, . . . . .	2.16
Albumin, . . . . .	Faint trace.
Sediment, . . . . .	No casts.

Case 5.—Female patient (married) aged 55, general condition well preserved, some arterial tension, some hypertrophy of left ventricle, but no pronounced indications.

	First Analysis.	Second.	Third.
Volume:			
Day, . . . . .	272 c.c.	440	730
Night, . . . . .	200 c.c.	360	480
	472 c.c.	800	1210
Specific gravity, . . . . .	1023	1020	1012
Solids, grammes, . . . . .	23	32	29
Urea in 1000, . . . . .	22	23	11
Urea, total, . . . . .	10½	18	13½
Phosphoric acid in 1000, . . . . .	1.98	1.45	0.88
Phosphoric acid, total, . . . . .	0.93	1.16	1.06
Albumin. . . . .	Plain trace.	Plain trace.	Plain trace.
Sediment: Hyaline casts, one granular cast found, uric acid, calcium oxalate.		A few hyaline casts.	A few hyaline casts.

The cases in Class IV., though not of pregnancy, are described because in some of them the urine is typical of various types of renal lesions, and which, if encountered *during* pregnancy, would arouse our suspicions. I have records of many more analyses, but unfortunately know nothing of the subsequent history, hence do not publish them.

Looking over these analyses, and knowing the outcome of the cases, the following conclusions would appear to be warranted :

I. Urine typical of degenerative or inflammatory conditions in the kidney is seen in the cases above, as follows :

Class I.—Cases 1, 2, 3.

Class III.—Case 1.

Class IV.—Cases 1, 2, 3, 5.

Such urine presents the following characteristics : It may be either normal, increased or decreased in quantity ; its specific gravity (on which so many rely as a guide) may be normal, increased or decreased, but in the three cases of Class I., which terminated fatally, *urea was below the minimum normal average* (that of Yvon-Bérlioz) *in nineteen out of twenty-four analyses*. In the case which proved most rapidly fatal from the time that objective symptoms were noted, *urea was never higher than eleven grammes, though the amount of urine in twenty-four hours was full normal in four out of eight collec-*

tions, and twenty-four hours before death from convulsions was diminished but one-half in quantity. In Case 2 of Class I. the patient did not succumb until the quantity of urine was reduced practically to nothing, the urea keeping pace with the urine. *The specific gravity in this case was always normal (1022), or above normal.* When, therefore, a pregnant woman or any person is albuminuric, reliance must *not* be placed (a) on the fact that the quantity of urine in twenty-four hours is normal, or (b) that the specific gravity is normal. Further investigation of the character of the urine is necessary, both by chemical and microscopical tests. If now during pregnancy or at any time, albumin appears in the urine, and the urea is greatly decreased RELATIVELY, the case is more likely to become either rapidly or suddenly fatal than one in which the quantity of urea keeps pace with the quantity of urine. In the rapidly fatal case (Class I., Case 1) the percentages of urine and urea compared with normal were as follows :

	1st.	2d.	3d.	4th.	5th.	6th.	7th.	8th.
Urine in 24 hours, .	100	100	100	100	No	75	80	55
					Rec.			
Urea in 24 hours, .	55	40	45	40	No	40		30
					Rec.			
Normal average = 100.								

II. On the other hand, urea may not be greatly reduced in quantity, but if albumin be abundant and long, straight, dark, granular casts present (Class I., Case 3), the condition is probably hopeless, as has been shown by Edis after a study of many cases.

III. Furthermore, there are cases in which albumin suddenly appears with or without casts, and eclampsia may take place without much warning objectively. But a study of the urine will show a deterioration in its quality preceding the convulsions.

Such a case is seen in Class II., Case 1. It is true that in this case the deterioration in the quality of the urine was not great, but it is also to be noticed that the patient recovered after nearly a score of convulsions ; it is at least doubtful whether "uræmia" had anything to do with the convulsions.

IV. Next, in cases where the volume of urine is very much reduced, an amount of albumin which, if present in 1200 to 1500 c.c. of urine, would not excite especial remark becomes very noticeable.

Class III., Case 1, illustrates this point. I have on several occasions seen the urine reduced to one-third or one-quarter its normal amount, and a large percentage of albumin appear. The specific

gravity is high, urea percentage is higher than normal, though in total amount far below normal, corresponding to the volume of urine. But no casts can be found in the sediment; even small hyaline casts are wanting. Now wait a day or two and pus in abundance appears, the quantity of urine increases and the percentage of albumin diminishes (Class III., Case 1).

The prognosis in these cases is favorable, *always provided* that the patient is not oedematous and has no general uræmic symptoms, nor those of typhoid uræmia. Provided also, that the urine has no foul odor, that the pus settles well with clear urine above it, is comparatively free from micro-organisms, etc.

V. It is possible to find the urine decreased in volume about the seventh month, of somewhat deteriorated quality as regards urea, and containing a trace of albumin. In such cases frequent collections and analyses should be made, and general precautionary measures taken to prevent an attack of acute nephritis. There is probably a hyperæmic condition of the kidney, and the patient is liable to nephritic complications, or to the development of any latent trouble, especially if there is any inherited tendency. Such a case is shown in Class III., Case 2. Precautionary measures were taken and the urine improved in quantity and quality. No nephritic attack occurred and the patient went safely to term.

Class IV., though not of pregnancy, is of general interest. Case 1 illustrates the urinary condition which may be found in paralytic conditions. Cases 3 and 4 illustrate the condition of the urine in patients convalescing from acute nephritis. If the history were not known, chronic nephritis might be suspected. Cases 2 and 5 are, indeed, those of chronic nephritis. Case 5 shows very well the marked features of the urine before any objective symptoms of consequence are to be noted. In this case the patient has contracting kidney in the early stage, before cardiac hypertrophy is at all well marked. It will be noticed in the third analysis that the phosphoric acid is remarkably diminished. Representing the condition of the urine by the method described in my third paper, we have in Case 5 the following:

Normal = 100.			
	First Analysis.	Second.	Third.
Volume of urine, . . . . .	40	65	100
Urea, grammes per litre, . . . .	115	120	60
Phosphoric acid, grammes per litre, . .	80	60	35
Urea per twenty-four hours, . . . .	50	90	65
Phosphoric acid per twenty-four hours, .	35	45	40

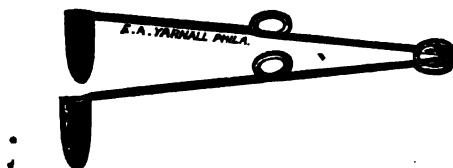


Comparing the phosphoric acid with the urea, it will be seen that in every case the deficiency in phosphoric acid is more marked than that of the urea. After making several hundred analyses, which I shall report in due time, I think I am warranted in saying that *a deficiency in phosphoric acid is one of the earliest signs of Bright's disease*; one which will be found in cases where knowledge of the quantity of urea is of little or no help in making the diagnosis.

### A NEW SELF-RETAINING WIRE NASAL SPECULUM.

BY HORACE F. IVINS, M.D., PHILADELPHIA.

THIS little instrument is made of a single piece of German-silver wire, to the ends of which are firmly soldered, at right angles, German-silver, non-fenestrated plates or blades. They are slightly concave on their opposing surfaces and correspondingly convex externally. The whole instrument is nickel-plated, thoroughly aseptic, and quite light.



Although it possesses most of the advantages of other specula, it has some individual points of merit. While absolutely self-retaining, owing to a double coil of the spring-end of the wire, its dilating quality is very elastic, and yet so mild that pain is almost never noted, and inconvenience is exceptionally occasioned. When the septum is very sensitive, the nasal vestibule may be well dilated, without causing pain, as the double coil of wire permits moderately free antero-posterior motion of the blades, thus enabling deep introduction of the alar blade, while the septal one is drawn forward and allowed to rest in front of the sensitive area.

The grasping surfaces are formed by single coils of the wire of each side, so that there is a firm rest for the finger and thumb without fear of the instrument turning in the grasp, and, as the coils are on the surface of the instrument farthest from the patient, the mustache is not easily caught and pulled when removing the instrument after it has answered the purpose of self-retention.

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

**DERMATITIS FROM VIOLET WATER.**—Dr. James C. White has had under his care a girl who presented a fine papular eruption of bright redness, sharply defined in outline, upon the front of the chest. Two days before she had rubbed the affected part with violet water, which was found to be a bright green alcoholic solution of orris root. The root of this European flag, *iris florentina*, seems to possess acrid properties similar to our native *iris versicolor*, and may well have been the irritating principle in this case.—*Journ. of Cutan. and Gen.-ur. Dis.*, February, 1890.

**A CONTRIBUTION TO THE HISTORY OF SYPHILIS.**—Dr. B. Scheube, of Leipsic, calls attention in Virchow's *Archiv* to a Japanese medical work which was written in 808 A.D. It bears the title *Dai-do-rui-shin-ho*—i.e., collection of recipes, arranged in classes, from the period of "Dai-do." The book is divided into one hundred chapters. The first thirteen contain a list of remedies; but in the remaining chapters, one hundred and twenty-two various diseases, i.e., symptoms of disease, are described. Among these is also syphilis. The places referred to are found in the ninety-fourth and ninety-fifth chapters.

The book is written in Chinese characters in Yamato Kotoba, the old language of the Japanese nation, hence the work is but imperfectly understood by a Japanese of the present day. The signification of several names of diseases was not to be determined, although several learned Japanese authorities were consulted.

The ninety-fourth chapter is as follows:

"Kata shine Kasa"—i.e., one-sided eruption of the femur.

"At the fold between the root of the thigh and abdomen, erythema and swelling, accompanied by violent pains and heat. After a few days it passes on to suppuration, and opening; much pus is discharged."

"Mara Kasa yami"—i.e., an eruptive disease of the penis. "At the beginning a swelling, painful, the size of a millet seed. After several days an ulcer and evacuation of pus.

"Fuse Kasa" (?). "In the vesicle of the eruption there is water contained; this appears especially during the summer. The penis is very much swollen and thickened; the swelling spreads over the entire penis, and no opening can be seen from the outside. Pus flows out of the skin."

"Shiri mara Kasa"—i.e., ano-penile eruption. "At first the eruption is confined to the above-named parts. Then ulceration with pains; after a few days the suppuration increases and the glans falls off. After this the ulceration gradually spreads posteriorly, the penis falls off, and the ulceration passes over to the scrotum."

"Hashiri Kasa"—i.e., running eruption. "The virus of the penile or femoral eruption ascends, and a running discharge follows. Heat and rigors appear, and the bones of the extremities are painful. After a few months a small eruption, painless, and with no itching, appears upon the back and face. A yellowish fluid discharges therefrom. A few months later the face becomes putrefied and stinks, and pus is discharged."

To this is annexed the ninety-fifth chapter.

"Hone-no-hari-Kasa"—i.e., an eruption "marked by bony swellings. After healing of the penile eruption the joints pain, so that they can neither be extended or flexed. There is general heat, then the poison ascends and various bad symptoms make their appearance, against which the following recipes are to be used. . . . The bones become painful, the sick man becomes feverish, lasting the entire day, and he cannot eat. There is constipation; the urine is red and voided with difficulty."

"Nondo fuki Kasa"—i.e., pharyngeal eruption. "The remaining poison of the penis ascends, the membrane of the pharynx swells, and the sick man has pain. After several days suppuration appears, much pus is discharged, and gradually decay sets in, which does not heal for several years."

"Ana Kasa"—i.e., pinched-out eruption, and "hi Kasa" (?). "The remaining poison of the penis ascends and destroys face or head. For several decades there is no cure possible. The poison yet remaining takes its seat in the head, and destroys the skin, flesh, and bones. Then the ears are either destroyed or there is nasal discharge. The nose falls off, blindness appears or the entire lower extremity swells and pains for several years; then they decay. The virus destroys the entire body, or the scrotum is covered with an eruption. It swells and decays, or comes to the formation of numerous holes. Thereupon the entire surface of the body is destroyed."

"Mimi-no-hi-Kasa"—i.e., ear eruption. "The remaining poison ascends, and roaring in the ears, with difficult hearing, makes its appearance. After several months violent pains appear and a purulent fluid flows from the ear. Then there is no more roaring, but the patient can no longer hear."

These are the places which refer to syphilis in *Dai-do-rui-shin-ho*. We see, according to the order of their appearance, the bubo, the chancre, the oedema preputii, the phagedenic chancre, the exanthemata, the bone and joint affections, the ulcers of the fauces, and the grave tertiary symptoms described in a few words, and finally the otorrhoea, which hardly belongs here.

The relation of all these affections was known to the writers, hence they regarded syphilis as a specific disease. Whether they regarded it as contagious, especially if transmissible by sexual intercourse, is not to be seen, for the Chinese and Japanese medicines regard other non-contagious diseases as originating in especial poisons.

In addition, the names may be added which are now used in Japan for syphilis. The scientific names are "Bai-doku"—poison, and "So-doku," "so"—eruption. The people call this disease "Kasa," or "Huje."—*Journ. of Cutan. and Gen.-ur. Dis.*, February, 1890.

**CORYZA AND QUILLAYA.**—Gretschinsky witnessed for years very salutary effects in acute and chronic coryza by insufflation of finely pulverized root of quillaya saponaria; it suffices even to shake the powder on a sac during breathing through the nose. The secretion increases at first and then stops. Acute cases are cured in one day, chronic cases in three or four days.—*Allgem. Centr. Medic. Zeitung*, 1, 1890.

[The United States Dispensatory speaks only of the soap bark, whose powder, snuffed into the nostrils, provokes free secretion and sneezing, and might be used as a sternatory. The National Dispensatory also mentions it as a febrifuge and acting similarly to senega. On the Pacific coast it is considered a favorite remedy among the people in all throat and bronchial affections, and many homoeopathic families use the tablets in the third or sixth potency for the same trouble. It is certainly a remedy which deserves proving.]—S. L.

**DIPHTHERITIS AND BREWERS' YEAST.**—Dr. Babel finds no remedy equal to brewers' yeast, a teaspoonful every two hours, in the treatment of diphtheria, and where it cannot be got, compressed yeast-cakes are a very good substitute. This treatment should be brought to the notice of the profession in order that it be properly tested.—*Allgem. Med. Centr. Zeitung*, 1, 1890.

[The antizymotic or antibacterial effect of brewers' yeast is well known, and in enteric fever I do not know any treatment which promises better results from the start, and I never saw yet a patient who not only did not object, but relishes it when taken in water or milk.]—S. L.

**TREATMENT OF TETANUS BY ABSOLUTE REST.**—De Renzi has, for some time, insisted that absolute rest is a most important factor in the treatment of this fatal malady. He has cured four out of five cases by this method. The patients were completely isolated in a darkened room and their ears stopped; all necessary manipulations were made, when possible, in the dark; a liquid diet was given and complete bodily rest insisted upon. If they suffered violent pains, belladonna and secale cornutum were administered internally.—*Riv. Chir. a Terapeut.*, No. 1, 1889.

**HEART-FAILURE CELLS.**—In a recent article in the *Deutsches Archiv für klin. Med.* (October, 1889), Professor Hoffmann again calls attention, from a clinical stand-

point to the significance of certain cells, to which he has given the above name, occurring in the sputum in cases of brown induration of the lung in mitral disease, myocarditis, and pericarditis. These cells are distinguished by their size, more or less oval form and beautiful balloon-shaped nucleus, but more especially by containing yellow and yellowish-brown to brownish-red and black pigment. It is not easy to confuse them with other cells. They resemble in all points the desquamated epithelium of the alveoli, and are characterized by their pigment shading yellow to brown. Hoffman regards the "heart-failure cells" as desquamated alveolar epithelium, and considers their presence in the expectoration as a sign that brown induration of the lung is present. Professor Sommerhardt refers their origin to proliferation of alveolar epithelial cells, which swell up and absorb the red blood corpuscles extravasated into the lumen of the alveoli, becoming ultimately pigmented by the alteration of the corpuscular coloring matter. Hoffmann maintains, however, that in the lung, in heart failure, these cells are derived from those under the epithelial covering; and, partly by diapedesis, partly by capillary hemorrhages into the lung tissue, obtain their pigment. Whatever view may be taken of the derivation of their pigment, their significance as a sign of heart failure does not seem to be questioned. In the *Practitioner*, February, 1890, Lenhartz considers that at least the great majority of these pigment-cells are more or less altered leucocytes, holding within them bits of red-blood corpuscles. As, however, some writers have met alveolar epithelium containing pigment, he will allow that some of the pigment-cells are epithelial. A natural objection to Lenhartz's view is, that a similar pigmentation ought to occur in croupous pneumonia, and in the hemoptysis of phthisis. He claims, however, that in these last the conditions are not so favorable as in mitral incompetence. Here we have no transitory process limited in area, but a long continued state of affairs favorable to diapedesis, and rupture of vessels and uninterrupted action of the leucocytes. The practical outcome of this minute inquiry is, that Lenhartz agrees with Hoffmann throughout in considering these pigment-cells as characteristic of the lung of cardiac incompetence.—*Medical Chronicle*.

**VALVULAR DISEASE OF THE HEART.**—At the regular meeting of the London Medical Society, Dr. Seymour Taylor showed a case of severe valvular disease of the heart, occurring in a seamstress aged 26. She presented all the typical signs of aortic obstruction and regurgitation, of mitral regurgitation, and also, he thought, of mitral obstruction. The valve disease probably dated from two attacks of rheumatic fever; the first, ten years ago, the second occurring seven years ago. The chief point of interest was, that her physical signs outweighed in severity her symptoms. She was still able to go about and follow light occupation; and his contention, from watching a number of such cases, was that the presence of mitral regurgitation was rather beneficial to her than harmful. He had already shown a series of cases in which double aortic disease alone existed, and compared them side by side with another series in which the aortic lesions coexisted with mitral regurgitation, and in all the evidence showed that those cases with the graver disease had more comfort and less dyspnoea and palpitation than those in whom the aortic lesions alone were present. This he considered to be due to the mitral insufficiently acting as a safety-valve to the over-distended ventricle, and in such cases he found hæmoptysis was a relief. Whether, in the case shown, the mitral regurgitation was the result of the aortic disease and its secondary dilatation of the ventricle, or whether it was due to the same cause (acute rheumatism), he could not say; he believed, however, that all the valves were affected by the same illness. But, whether contemporary with, or secondary to, the aortic disease, the effect was the same: she had now some degree of comfort even with her advanced aortic disorder. Dyspnoea was an early symptom in mitral disease, and a late one in aortic regurgitation. This was supposed to be due to lung congestion being an early condition in the former, and the dyspnoea was pulmonary. But there was another form of dyspnoea which was mainly cardiac, and this, occurring early in the history of a case, was frequently found in aortic disease. Then, given mitral regurgitation, or a safety-valve overflow, this form of dyspnoea remained in abeyance for some considerable time, or at least until such a period when the general nutrition of the heart-muscle was irretrievably impaired.—*The Lancet*.

**SCABIES TREATED WITH PETROLEUM.**—A writer in the *Revue Gen. de Clinique* advises the following treatment of scabies: On the first day the patient anoints the entire body, with the exception of the head, with petroleum, and rubs it in thoroughly over the spots where the itch mites are to be seen. He then dresses

for the night and retires. The next morning he washes himself all over with warm water and soap, changes his linen, and goes about his daily avocation. This process is repeated on the two following nights, after which the patient can be discharged as cured. This treatment may be applied even in persons of most delicate skin. Where excoriations or scabs exist from scratching, they will disappear rapidly.

**TWO CASES OF INTESTINAL OCCLUSION TREATED BY INJECTIONS OF SULPHURIC ETHER.**—Clausen recommends the following treatment for intestinal occlusion: Ten grammes of ether are dissolved in alcohol, to which three hundred grammes of distilled fennel water are added. This mixture is then introduced into the rectum as high up as possible. The patient experiences a painful sensation of heat, and immediately afterwards has eructations with the characteristic ethereal odor. This is soon followed by copious fecal stools, and the colic and all the morbid manifestations pass away. Either excites increased peristaltic movements of the intestines, and these remove the occlusion.—*Bullet. gen. de Therap.*

**THE RELATION BETWEEN CARDIAC NEUROSIS AND AFFECTION OF THE NASAL PASSAGES.**—Stein, of Moscow, teaches that a more or less developed hyperplasia of the turbinated bodies, without symptoms of irritation, but with either temporary or permanent obstruction of the nasal passages, may cause in the cardiac region a sensation of heaviness, compression and anguish. We often meet in these cases an injection of the conjunctiva, and of the tip of the nose, which can be produced by a mere touch of the nasal mucous membrane, and is followed by palpitation, dizziness, dyspnoea and heaviness. In many cases the lower turbinated bodies are red-dened. One often meets in these cases with more or less dilatation of the cutaneous capillaries over the tip and dorsum of the nose and of the cheeks.—*Munch. Med. Wochenschr.*, 4, 1890.

**MALARIAL INFECTION.**—At the Italian Medical Congress, held in Rome, Bacelli presented a paper offering the following conclusions: 1. Malaria is an infecting agent. 2. Its physio-pathological process consists in an hæmodyscrasia and a neuro-paralysis. 3. In the blood the red corpuscles are chiefly affected; in the nervous system the ganglionic substance. Malaria is a pyrogenous and not a phlogogenous process, and inflammatory symptoms are only secondary manifestations. The parasites cannot be found in every case. Marchiafava mentions that the malarial parasites develop inside of the red-blood corpuscles, taking their nourishment from the hæmoglobine and changing it into melaine.—*Munch. Med. Wochenschr.*, 3, 1890.

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## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

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**ATMOSPHERIC PRESSURE AS A CAUSE OF RETENTION OF THE PLACENTA.**—Rodríguez explains a theory of Dr. P. Gavilan, of Durango, with regard to certain cases of retention of the placenta by atmospheric pressure. He, in such a case, having introduced the hand into the uterus, found it impossible to loosen the borders of the placenta; so, with his fingers, he pierced the central part of it, when at once, before he had time to make traction, the after-birth lay loose in his hand. He thinks that when the edges of the placenta adhere too firmly, and traction is made on the cord, a vacuum is formed in the centre; when the air enters, by introducing the finger, the placenta is expelled.—*London Medical Recorder*, February 20, 1890.

**VARICOSE VEINS IN THE VAGINA AS A CAUSE OF ACCIDENTAL HÆMORRHAGE.**—Mr R. C. Benington reports the case of a woman who engaged him to attend her in confinement, which she expected to take place about five months later. During her previous pregnancy she had frequent attacks of flooding. A week or so after her first interview with him, she had a slight hæmorrhage without pain, the exact nature of which was not ascertained by a vaginal examination. A vaginal exami-

nation made one month later showed the vagina to be full of structures that felt exactly like soft, movable sausages. The labia were very much enlarged, and varicose veins were everywhere apparent, and inside the vagina were veins black and tense, as large as a forefinger. Shortly after the examination was made, and while the patient was standing, a great flow of blood, lasting about one minute, took place. An examination made within a few minutes showed that the previous condition had completely disappeared. Two weeks later she had another hemorrhage of the same character as before. One month later she miscarried. She made a good recovery. — *Medical Press and Circular*, January 15, 1890.

**THE INFLUENCE OF INFLUENZA ON THE FEMALE GENITALS.**—Bierner and Gotschalk observed metrorrhagia, and, in a case of menorrhœa, the reappearance of the flow during an attack of *la grippe*. The hemorrhage set in during the first or second day, and was preceded by sacral pains and great urging to urinate. It lasted from five to eight days, and necessitated hot injections and the internal use of hydrastis. In all cases they found a considerable swelling of the uterus, which felt soft and flabby; its mucous membrane was sensitive to the touch, without any roughness on its surface, and its cavity enlarged. They observed two cases of abortion as a result of the influenza. In no case could inflammatory conditions of the tubes or ovaries be found. — *Centralblatt f. Gynäk.*, 1, 1890.

**DOES OPIUM PASS THROUGH THE MOTHER TO THE NURSING BABE?**—Febrini and Cantee report a case of opium-poisoning in a babe who nursed from a woman who repeatedly inserted cotton soaked with laudanum into a carious tooth to relieve toothache. This led to experiments with a goat. Morphine was injected subcutaneously, and chemical analysis demonstrated the presence of the alkaloid in the milk of the animal. The clinico-chemical studies of Panzano, of Bologna, led him to different results, though Taylor, Schmidt and Edwards also report cases where infants died from doses of one-twentieth to one-sixteenth of a grain. Fehling, on the contrary, never observed such fatal issues, not even somnolence, in the babe when the nurse took opium. He made six clinical experiments with twelve nurses and thirty babes, giving the nurses morphia and laudanum by the mouth for several days, and never witnessed any deleterious effects of the same on the infants. — *Wien Medical Wochenschr.*, 4, 1890.

**FORCEPS AND THE AFTER-COMING HEAD.**—William Goodell says: "The forceps is the only proper aid in the expulsion of the after-coming head. The fingers in the fetal mouth are useless, and there is danger of breaking the jaw. The body of the child should be held away, so that the forceps can be applied to the sides of the head, the handles being on the anterior aspect of the child's body." — *Archives of Gynecology*, January, 1890.

**COCAINE IN LABOR.**—A. L. Wagner, M.D., uses cocaine in all cases, especially when called early, or when called late if there are reasons to believe that labor will be prolonged. In those cases when the membranes are prematurely ruptured, or where the os is unnaturally rigid, the pain from dilatation of the cervix is unusually severe, and labor is abnormally prolonged. In these cases, as well as in normal labors, cocaine not only annuls the pain, but it also permits or causes a more ready dilatation by paralyzing the circular fibres of the os.

My experience has been that, instead of waiting from four to twenty-four hours, by the aid of cocaine the labors have been about two hours long, i.e., from the time of sufficient dilatation of the os to admit the finger, to full dilatation and expulsion of the fetus. After full dilatation of the os but few pains are required to expel the fetus.

It not only shortens labor, but it annuls the pain to such an extent that the patient, if in sharp pain, soon manifests her freedom from it by remarking that labor is not progressing as it should, because she feels the pains less energetic. He uses in almost all cases cervical suppositories containing from 2 to 3½ grains of cocaine, and about one to one and a half hours apart, never using more than two in one case. Subcutaneous injections into the perineum or sides of perineum are also used. After birth, the vagina is cleared of the cocaine by an antiseptic douche. — *Archives of Gynecology*, January, 1890.

**LACTATION DURING MENSTRUATION.**—Ever since the days of Hippocrates and Galen, the belief has obtained that perfect lactation was inconsistent with the return of the menses. In a paper recently read before the Royal Medical Society of

Vienna, by Dr. Schlichter, the result of this belief is seriously called in question, and there seems good reason to conclude that the effect of menstruation on the milk is not necessarily detrimental. The author analyzed a number of samples of milk, obtained from menstruating nurses, with the result of showing that the relative proportion of casein had undergone no diminution. The fat was variable, but no more so than in non-menstruating nurses, and the maximum occurred just as often during a menstrual period as after or before. He remarked that, in the cow, the advent of the rut does not produce any noteworthy variations in the quality of the milk. Taking the results of the analyses as a whole, it was found the variations in the quality of the milk before, during and after menstruation were not as marked as in milk drawn at different hours of the day under ordinary circumstances. An examination of the infants, moreover, failed to demonstrate any constitutional disturbance or failure of nutrition, provided the menses did not return earlier than the sixth week.—*Medical and Surgical Reporter*, February 15, 1890.

**REMOTE RESULTS OF CASTRATION FOR FIBROIDS OF THE UTERUS.**—Dr. Wiedow reports sixty-six cases, with five deaths, i.e., a mortality of 7.6 per cent. Four of these deaths occurred in the first twenty-four operations. In order to give more accurate statistics, only those cases are mentioned which have been under observation three or more years after the operation. These number thirty-seven. In twenty-one of them the menopause occurred immediately after the operation. In fifteen cases the menopause took place with bloody discharges once or several times. In one case the menses ceased for six months, and then there were regular, weak menstrual periods. He is positive that no portion of ovarian stroma was left behind. In twenty-four cases out of thirty-three of large fibroids, the tumor disappeared completely; eight tumors underwent marked diminution, and only one showed no decrease. In view of these favorable results, Dr. Wiedow would only extirpate the fibroid in pedunculated sub-serous or sub-mucous tumors, fibro-cystic tumors and those of extremely large size.—*Centralblatt für Gynäkologie*, No. 7, 1890.

**TREATMENT OF PUERPERAL SEPTICÆMIA BY CURETTING THE UTERUS.**—Charter reports good results as the result of twenty-six observations. It is easy to perform; neither is narcosis nor dilatation of the cervix necessary. He believes it indicated when improvement does not follow intra-uterine injections, and especially when portions of the placenta remain in the uterus. Complications, with disease of the appendages and peritonitis, are contra-indications.—*Centralblatt für Gynäkologie*, No. 7, 1890. (This method of treatment is employed in the wards of Prof. Karl Braun in Vienna with success. I found many of the cases did well afterward, but the treatment had not been adopted in the second division up to the time of my last visit there in August.—G. R. S.).

**SCANZONI'S METHOD OF CHANGING CRANIAL PRESENTATIONS WITH THE FORCEPS.**—Dr. Aly, in presenting this subject before the Obstetrical Society at Hamburg, contends that abuse of the operation brought it into discredit. He was of the opinion that a very valuable method was being neglected, and that in using it Scanzoni's conditions and indications must be strictly observed. These are: 1. The operator must make an exact diagnosis of the position of the head. 2. The head must be deep in the pelvis and be well grasped by the forceps, with proper respect to any anomaly of the pelvis. 3. The mother or child must be in danger. This operation of Scanzoni (rotation of the head with the forceps) is not in accordance with modern text-books or obstetrical teaching. Winckel does not mention it in his text-book. Spiegelberg warns against it. Schroeder advised waiting till the head rotated, or extracting with the occiput posterior. The translator could mention many other text-books expressing similar opinions. In the discussion following, Dr. Lomer vehemently opposed the use of the forceps as an instrument for rotating the head. He had seen a healthy young woman lose her life in consequence of it. The very fact that all modern obstetrical teaching opposed it showed that others had experienced similar results. When a large head is fixed in the pelvis, the amniotic fluid having escaped, the head becomes moulded and conforms to the shape of the pelvis; rotation of the head with the forceps, under these conditions, will either fail or be attended with severe injury to the mother. If extracted without rotation the most severe maternal injury will be a deep perineal laceration. If the head be small or the pelvis large, the head can be brought down to the floor of the pelvis in the ordinary manner with the forceps. It will then almost always rotate. If it should fail, Ritgen's method is to be employed. Prof. Olshausen ex-

pressed the opinion that only those possessing exceptional skill should attempt the method. He remarked that the introduction of a single blade, and using it gently as a lever, was often sufficient to rotate the head.—*Centralblatt für Gynäkologie*, No. 5, 1890.

**SPLITTING THE CERVIX IN REPAIRING CERVICAL LACERATIONS.**—Dr. Dührssen has proposed this operation, which is performed by an incision  $\frac{1}{2}$  cm. deep antero-posteriorly over the torn surfaces on anterior and posterior lips. The two flaps are held apart, so that the cut surfaces of the lips correspond to each other. Sutures are inserted in the usual manner.—*Centralblatt für Gynäkologie*, No. 4, 1890.

(No tissue is cut away, and for this reason the operation may be desirable in secondary operations on the cervix, and where there has been sloughing of tissue. It has the great objection that no hypertrophied glandular, connective or cicatricial tissue is removed, which is absolutely essential in operating on many cases.—G. R. S.)

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**BLINDNESS FROM BABIES' SORE EYES.**—Reliable statistics show that at least 30 per cent. of all the blindness in Europe and this country is caused by ophthalmia neonatorum. Bringing the matter more home to ourselves, we find that the census of 1880 gave the total number of blind in the United States as nearly 50,000. Of these there are at least 15,000 who have been blind from birth, and have been a constant care and expense. Many of them, it is true, are still in infancy and at an age when they would, under ordinary conditions of good vision, still be a charge to society; and there are a very few blind people who are in some way or other self-supporting. But, as even more than an offset to these, are those whose vision, while not lost, has been seriously impaired, and who are thereby greatly handicapped in the work of their lives, that have not been reported in the census under the heading "blind." Only those who are totally blind are enumerated in the census reports; even very serious defects of the senses are, I believe, not taken account of. It is then, I think, safe to say that there are 15,000 people in this country who are a charge upon the community as a result of blindness from ophthalmia neonatorum. That the latter statement is not a chimerical fancy, nor an optimistic exaggeration, is readily seen by reference to the reports of the large lying-in hospitals, where the most methods of prevention have been in operation. Take, for example, the reports of the hospital at Leipzig, under the direction of Prof. Crede, who was the first to use and bring permanently forward the method now well known by his name. In the years before his preventive measures were used blennorrhœa of the conjunctiva occurred in from 7 to 13 per cent. of all the children born in the hospital. After the method was put in operation there was practically an entire disappearance of the disease, only an occasional case showing itself as the result of some neglect on the part of an attendant. Reports from other hospitals, in Berlin, Bonn, Dresden, Geissen, Marburg, and other cities, bear equally good testimony to the system, none of them reporting more than 0.5 per cent. of cases. The method of Crede is as follows: Immediately after the umbilical cord is tied, the face and eyelids are wiped clean and dry. The lids are then opened, and a drop of a 2-per cent. solution of nitrate of silver is dropped in from a glass rod or by other proper means. The one application suffices, if properly made. This has been considered by some as needlessly heroic, and it is probable that in the large majority of cases a solution of even 0.5-per cent., or the use of another and milder antiseptic, or even proper cleansing with water, would prevent the outbreak of the disease; but for a sure and certain prophylactic a 2-per cent. is needed. Housemann's method of a thorough cleansing of the maternal passages with antiseptics before and during delivery, is, of course, useful, but it cannot take the place of the prophylactic measures applied to the organ likely to be affected, or perhaps already holding the germs of disease. It is obvious, then, that our first duty is to arouse our teachers and writers on obstetrics to the necessity of instructing their pupils as to the proper



care of the eyes of the child from the very instant of its birth. If they are not willing to adopt what they may consider the heroic method of Crede, let them at least be instructed to wash the eyes with some antiseptic solution and examine into their condition at each visit for at least a week. This would, at any rate, keep the attention directed to the eyes, and allow for the discovery of the first manifestation of the disease, and in time—and at the only time—for its most successful treatment.

A few words in regard to the proper management of the disease when once it is set up: The first and most important thing is cleanliness. The eye should under no circumstances be bandaged. Free exit should be given to the discharge, and the matter should be wiped off with a sponge, or better still, absorbent cotton dipped in antiseptic solution, as fast as it is formed. This, of course, necessitates constant and unremitting attendance. The eyelids should be opened as wide as possible, and the matter washed off the conjunctiva of the everted lids with a stream of antiseptic, or at least, aseptic liquid, such as a solution of boric acid, or of sublimate 1 to 5000, every fifteen minutes, or every hour, according to the quantity of the discharge; and three times a day, the conjunctiva, after it has been wiped dry, should be wiped over with a 1- to 2-per cent. solution of nitrate of silver by means of a camel's-hair brush. As the swelling and discharge diminish the interval between these applications is to be lengthened. All cloths, sponges, or cotton used in connection with the eyes should be boiled or otherwise disinfected, or, better still, burned; for not the least of the dangers of the disease is the liability to infection of the eyes of the attendants. And for this reason, also, the hands of those treating or examining such eyes should be carefully cleansed and disinfected immediately afterward—Dr. Swan M. Bennett, in the *Medical Record*, February 11, 1890.

**ABSCESS OF THE CORNEA.**—Dr. H. F. Hansell says that the results of clinical observation pursued by him during the past year go to show:

*First.*—That eserine is superior to atropine.

*Second.*—That cocaine is a symptomatic remedy only, and when long continued is injurious.

*Third.*—That the Saemisch operation is in most cases inferior to a simple division of the abscess.

Two objections have been raised against eserine: First, that the danger to vision, on account of the small pupil produced, is increased. This objection is just, and should be considered. Care must be taken that the contraction of the iris and ciliary muscles does as little damage as possible. To guard against permanent closure of the pupil, and constant spasm of accommodation, instillations of eserine should be alternated with instillations of atropine, or, the former may be used by day and the latter by night. These two remedies are therapeutically compatible, and when employed in the same case, with the full understanding of their effects, they give the best results. If, however, the abscess threatens to destroy the vision, the possible danger from posterior synechiae and pupillary membrane should be risked. It is then a choice between two evils.

The second objection is, that headache follows the use of eserine. This is invariably observed, yet, in his experience, it has not proved a real obstacle. When eserine is recognized as the cause, and explained to the patient, the importance of the headache vanishes. The pain is not intense, and subsides in from one to two hours: and when, exceptionally, it interferes materially with the patient's well-being, the strength of the solution may be decreased. Stronger solutions than two grains to the fluid-ounce are not advisable. As a remedy, cocaine has no place in the therapeutics of the cornea. It is deservedly high in esteem as an anæsthetic for the surface of the eye, and as an aid to atropine and other myriatics in dilating the pupils. It is a well-known fact that it destroys the anterior epithelial surface of the cornea, and this occurs when used in weak as well as strong solutions. If the applications are frequently repeated superficial ulcers and opacities result.

Operative treatment should, in the opinion of the writer, be limited to the division of the anterior surface of the abscess and evacuation of the pus. The disadvantage of the Saemisch incision is that the anterior chamber is opened, and thus anterior synechiae or dislocation of the lens is apt to result.—*Medical News*, March 8, 1890.

**ELONGATION OF THE UVULA AS A CAUSE OF LARYNGISMUS IN CHILDREN.**—Dr. Alfred Mantle, after reviewing the commonly-accepted sources of laryngismus, desires to call attention to yet another cause, which experience has taught him occa-

sionally exists. Was called to see a child eight weeks old and decidedly rickety, who, while being nursed upon its mother's lap, suddenly stopped breathing; the eyes were fixed and directed upward; the conjunctivæ were insensitive to touch; there was lividity of the lips and face. A struggle for breath took place, followed by a shrill inspiratory sound, the attack then suddenly ending with the child crying. These attacks came on often, both by day and by night, the mother stating that she had always to raise the child up quickly to prevent it suffocating. Treatment applied for laryngismus, due to rachitis, proved of no avail. Some time later, an examination of the throat showed a very much thickened and elongated uvula. Astringents having no beneficial effect on this condition, and the child growing no better, in fact, general convulsions and a certain amount of exophthalmia setting in, the uvula was removed and, with the exception of one slight attack on the same evening, no further spasm took place. While the writer has never seen a case in which there was so much thickening of the uvula as in this one, he has nearly always, in cases examined since, found the soft palate considerably congested, and would strongly urge every one to examine the fauces in every case of laryngismus.—*British Medical Journal*, February 8, 1890.

ATROPINE TO THE CONJUNCTIVA CAUSES NASAL HÆMORRHAGES.—A student, æt. 17 years, complained of pain in the eyes and progressive impairment of vision with some photophobia. Examination showed myopia of about 9° in each eye, and a small posterior staphyloma. No myopia in the family. In addition to advising rest for a few weeks, and the wearing of smoked glasses, the patient was directed to drop into his eyes, twice daily, a weak solution of atropine sulph. Two days later the patient complained that, after each instillation, he was seized with profuse bleeding from the nose, which came on at the end of five or ten minutes after the instillation, and lasted a quarter hour. There was no dryness of the throat nor vertigo. Suspension of the remedy resulted in cessation of the bleeding, and its reapplication was followed by an immediate return of the epistaxis. A substitution of du-boisine had no effect, except to lessen the severity of the bleeding. Astringents to the mucous membrane failed to arrest, or even lessen the hæmorrhage. The nasal cavity showed nothing abnormal.—M. Reich, in the *Archives D'Ophthalmologie*, February, 1890.

## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

INTERNAL URETHROTOMY.—Dr. G. E. Brewer reports one hundred and twenty cases of stricture operated by the method of Otis, with their accidents, complications and results, and draws the following conclusions: (1) Internal urethrotomy for strictures of the anterior urethra is a comparatively safe operation; (2) Alarming hæmorrhages can be avoided or arrested by the application of a few well-known measures, notably retrojections of hot water; (3) Subsequent curvatures of the penis are probably due to extension of the incision beyond the necessary limits. Early erections tend to prevent such a sequela; (4) With the exception of the meatus, the dividing of strictures in the anterior urethra on the floor of the canal, is dangerous and should be condemned; (5) The passage of sounds through the deep urethra should be avoided immediately after the operation; (6) In the majority of cases a thorough and complete division of all strictures results in a radical cure and a complete restoration of the canal to its normal calibre; (7) All attempts to prevent recontraction in imperfectly divided strictures by means of gradual dilatation are useless.—*International Journal of Surgery*, January, 1890.

DRAINAGE OF THE BLADDER AFTER EPICYSTOTOMY.—Burckhardt finds the same objection to the high operation as a great many other surgeons, i.e., the difficulty of draining the bladder. A catheter à demeure is of no use if the bladder wound be left open, and it cannot be relied on when the wound has been closed. If the opening is allowed to heal by granulation, the patient is constantly in an uncomfortable condition, owing to the difficulty of keeping him clean and dry.

To do away with these inconveniences the author has for the past five years made use of drainage by the perineum. This was first practiced in the eighteenth cen-

tury by Frère Come, but with another object, his plan being to open the bladder through the perinæum in order to introduce the *sonde à dard*, and with it open the viscera above the pubes. The writer quotes several cases in which he carried out this procedure with good results. For drainage, he makes use of a rubber tube, 1 cm. in diameter, with thick walls, the tube being perforated in a couple of places, and pushed up to the posterior wall of the bladder. No openings are made in the tube near the anterior wall or where it passes through the urethra. To hold it in place, a wire suture fastens it to the perinæum. The wound in the bladder is closed by catgut and the overlying wound packed with iodoform gauze. Heseldom allows the drainage-tube to remain in place over eight days.—*Centralbl. für Chirurgie*, No. 42, 1889.

**TWO DEATHS FROM CHLOROFORM IN CHILDREN.**—Sherman reports the case of a boy of five years who was chloroformed in the usual manner for a slight operation, when, after a few whiffs of the drug, the breathing ceased, but was restored as soon as the anæsthetic was removed and artificial respiration practiced. The chloroform was again administered, when, after twenty or thirty respirations, they again ceased. The heart stopped, the face blanched and the pupils dilated. Artificial respiration was again tried, the child was inverted, stimulants, such as whisky, ammonia, digitalis and nuxvomica were given hypodermically; hot and cold water was alternately applied to the chest, and the battery used, but nothing had the slightest effect. After an hour's work the case was given up as hopeless and further efforts abandoned. This patient had been chloroformed on two previous occasions, when anæsthesia was of longer duration; in this instance not more than a drachm of the drug being used. No difficulty was experienced in the former administrations. The author believes chloroform to be as dangerous for children as adults. Gibney also reports the case of a child two years of age who was kept under the influence of chloroform about ten minutes during the tapping of a *spina bifida*. At the end of this time the lips became blanched and the pulse feeble, when three minims of Magendie's solution of morphia were given hypodermically. The condition improved at once, but the pulse soon became feeble again. Forty drops of brandy were injected, when the patient ceased breathing, and all efforts at resuscitation, such as elevating the child by the feet, artificial respiration, Faradism, etc., proved of no avail. At the autopsy the heart, lungs and kidneys were found normal. A case like that of Dr. Sherman's was reported in the *Lancet*, September 14, 1889, where the autopsy revealed fatty degeneration of the heart, liver, spleen and kidneys.—*Medical Record*, March 15, 1890.

**THE CHOICE OF AN ANÆSTHETIC.**—In a recently published article in the *British Medical Journal*, Hewitt draws the attention of the profession to that much-neglected subject of anæsthesia, and shows the necessity for an intelligent discrimination regarding anæsthetics in any given case, in place of always using the same agent. The following points are to be considered in every case before choosing an anæsthetic: 1. Probable duration of the narcosis; 2. Nature of the operation and the procedures involved in the same; 3. Presence of some pathological condition which may contra-indicate certain anæsthetics. The author formulates the indications for and the contra-indications to the use of nitrous oxide, ether, chloroform and the "A. C. E." mixture, giving the preference to ether for general use, but sharply defining the limitations for its use; nitrous oxide gas for very brief operations, except in very young or very old subjects, or where any respiratory trouble exists, and also as a preliminary to etherization. The same contra-indications apply to ether, which also should not be used when renal trouble is present. Chloroform is preferable in abdominal work, and in operations involving the upper air-passages in which the actual canterly is employed, or when the site of the operation is such that the continuous administration of ether is made impossible, and the time required is greater than the ether insensibility would last without further administration, or where preliminary tracheotomy has been performed. Chloroform diluted with alcohol, or the "A. C. E." mixture, is to be used where ether is contra-indicated, but not when cardiac disease is present, or in cases of shock or collapse. Pure chloroform is regarded by the writer with wholesome respect, and its use limited to the utmost extent. It is to be given during labor as an anodyne only. It or the "A. C. E." mixture is preferable in cases of abdominal section, as it is less likely to cause retching after the operation, thereby lessening the danger of secondary hæmorrhage from torn adhesions, etc., more than in cases in which ether has been employed.—*New York Medical Journal*, March 8, 1890.

**THE FATAL AFTER-EFFECTS OF CHLOROFORM.**—It is well known that chloroform is occasionally the cause of death during an operation, but unfortunately it is not sufficiently heeded in some countries. But should the patient succumb a few hours after its administration the anæsthetic usually escapes blame, and the cause of death is laid to shock, etc. Recently, however, the profession has been awakened to the fact that every death following an operation is not due to hæmorrhage, peritonitis, etc., as more careful observations in the *post-mortem* room have shown that death oftentimes was due to some disease of the viscera, which may have existed prior to the operation and merely aggravated by it, or, what is not at all unlikely in the light of recent observations, the disease was evoked during the operation, or, in other words, by the anæsthetic employed. Cooper, as early as 1850, drew attention to chloroform intoxication following surgical procedures. Not long afterward, Langenbeck noted a death seventeen hours after operation, which he attributed solely to the narcosis; several others were reported about the same time. Since the experiments of Ungar, Strassmann, and Ostertag (see *HAHNEMANNIAN*, March, 1890) we should be awakened to the dangers of the indiscriminate use of either chloroform or ether. The latter, which is used more extensively in this country, although believed to be less likely to cause cardiac paralysis, its long-continued administration may be just as injurious in its after-effects, especially upon the kidneys. The practical point, however, is, do not surgeons of to-day display too much conservatism in arresting hæmorrhage? Is not too much time consumed in saving a few ounces of blood to the patient while his whole system is being poisoned by prolonged narcosis? It is to be feared that we have been led into an unsafe slowness in operating by the sense of certainty that the patient's sensations are abolished, and that we are apt to forget that our tardiness may be the means of causing a rapidly fatal or chronic disease of the vital organs.—*New York Medical Journal*, March 15, 1890.

**OPERATION FOR PROMINENT EARS.**—Keen reports a case in which the deformity from prominent ears was relieved by the following operation: An oval portion of skin was removed from the posterior surface of each auricle. A long narrow piece of the cartilage, V-shaped, in cross-section, was then cut out. This procedure differs from that practiced by Ely (1881), in that the skin of the anterior surface of the auricle is left intact. The cartilage on one side was united with catgut and then the skin; on the other, the skin alone. The result was very satisfactory.—*Annals of Surgery*, January, 1890.

**GANGRENE OF THE INTESTINE.**—Penrose calls attention to certain forms of localized gangrene of the intestine, in which the typical treatment by excision or presection is out of the question. Such a condition is found in abdominal suppuration, which, by extension of the inflammation, has caused destruction or perforation of the intestinal coats. Pus may thus open into one of the loops of intestine forming the abscess wall. Again, the same result may follow long-continued distension in obstruction of the bowels. The condition of such patients usually precludes a prolonged operation, hence the safest way in which the diseased gut may be left in the abdomen deserves consideration. The aim should be: (1) To place the diseased intestine in a position which will tend most to favor its restoration to health, and the one most favorable for the spontaneous or operative closure of a fistula. (2) To put off perforation or escape of feces until adhesions have taken place. (3) To prevent infection of the sound peritoneum. The intestine should be placed in a straight line, with the gangrenous portion facing the abdominal wall near the line of incision. The feces in this way easily pass the weak spot; there is the minimum of pressure, and consequently less danger of perforation, and the resulting fistula tends to heal spontaneously, or is easily closed by operation. If a perforation exists at the time of operation, it is usually small; the inflamed tissues will not hold the sutures necessary for closure, but the application of an omental graft will delay or prevent the escape of feces. Openings into the rectum, sometimes resulting from pyo-salpinx, cannot be closed by operation, but the tube being straight, they usually heal when the pelvis and the bowel are drained and frequently irrigated. Three successful cases are reported, treated on the above principles, and the author, in conclusion, insists on the following points as essential for success: (1) The bowels should be thoroughly cleaned out before the operation. (2) All obstructions below the gangrenous spot should be removed. (3) The diseased portion should be adjusted in a straight line. (4) The peritoneal cavity should be thoroughly drained and frequently irrigated.—*Medical News*, March 15, 1890.

# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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CONDUCTED BY

CHARLES MOHR, M.D., AND EDWARD R. SNADER, M.D.,

WITH THE COLLABORATION OF

S. LILIENTHAL, M.D.,

HORACE F. IVINS, M.D., AND EDUARDO FORNIAS, M.D.

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**GRAPHITES IN CONSTIPATION.**—Graphites is too much neglected, and it shows itself especially useful for women who are so apt to neglect the calls of nature and suffer in consequence thereof, often for years, from neurasthesia, female weakness, hæmorrhoids, and it does for women what sulphur does for men. We meet here Grauvogl's carbo-nitrogenous constitution. Copious masses of mucus often accompany each defecation, which Kafka considers the key-note for graphites. Scanty menses, often delaying; even a soft stool passes with difficulty; a diminished vitality everywhere, and graphites becomes our sheet-anchor, showing itself sometimes by distended abdomen and flatulency. Gastro-intestinal affections alternate with acne and erythema of the face, herpetic lesions or scrofulous hypochondriasis or hysteric melancholia, sleeplessness or disturbed sleep, occipital headache, with tension and stiffness of nape, or violent semi-lateral headaches, are all symptoms found under graphites, but at the same time we must not neglect dietetic and hygienic measures.—Dr. H. H. Goullon, *Zeitschr. d. Berlin Hom. Aerzte*, February, 1890.

**REMEDIES FOR ELEPHANTIASIS.**—Belladonna is indicated at the commencement of the affection to combat lymphangitis, after or conjointly with mercury. After subsidence of this stage phosphorus, silica, sepia and graphites are useful. Dr. Burkhard places special confidence in silica, while Mavlaender recommends kali chlor. internally and externally. For elephantiasis nostras Dr. Burkhard has used carduus and hamamelis with very satisfactory results, and has seen enormous legs reduced to their natural size.—*Revue Hom. Belge*, October, 1889.

**AURUM FOR LOSS OF HAIR.**—Dr. Burkhard recommends aurum for loss of hair following the abuse of mercury.—*Revue Hom. Belge*, October, 1889.

**NUPHAR LUTEA.**—Dr. H. D. Champlin thus summarizes, in a letter to the *March Homœopathic Recorder*, a few points concerning nuphar lutea: Loss of strength; excessive moral sensibility; diarrhœa, yellow, without colic in the morning; in evening, diarrhœa; there is much flatulence; chronic diarrhœa, stools watery, painless, quite copious, yellowish color, *very offensive*; frequent, as many as twelve in a day; a feeling of physical exhaustion is constant; urine deposits a copious red sand; skin, psoriasis.

**VERBASCUM THAPSUS IN HÆMORRHOIDS.**—Dr. Samuel A. Jones gives the following indications for verbascum in hæmorrhoids: Inflamed and very painful piles; scanty evacuation of feces in small, hard bits, like sheep's dung, with pressing; frequent or copious urination. This is also a pain in the belly that extends deep down, causing a contraction of the sphincter and a transient call to stool.—*Homœopathic Recorder*, March.

**NATRUM SULPHURICUM IN DIABETES**—Dr. Charles F. Goodell, in the *March Medical and Surgical Record*, reports the prompt amelioration following the administration of natrum sulphuricum 6, followed later by phos. acid 3, in a case of diabetes insipidus.

**LYCOPUS VIRGINICUS AS A HEART REMEDY.**—Dr. Stanley Wilde, in the *British Homœopathic World* for March, says: I have had some satisfactory experience with *lycopus Virginicus*. In one of the worst cases I have ever seen of pericarditis, complicated with bronchitis, where the respirations reached as high as 84 per minute, *lycopus* tincture, in one-drop doses, was the only medicine that gave any relief, the usual remedies having been previously tried. The respirations, the fever and the cough were all markedly diminished in the course of twelve hours after commencing the *lycopus*, and the patient made a perfect recovery.

Another case was that of a young woman, who, since an attack of acute rheumatism two years previously, suffered much from palpitation and darting pains in the cardiac region. There was a systolic bruit at the apex. *Spigelia*, which usually helps these symptoms, failed in this instance, but *lycopus* soon produced an amelioration, and, after taking it for a month, there was a complete cessation of both pain and palpitation.

**DIOSCOREA.**—The chief landmark is the peculiar pain embracing the umbilicus, the size of a silver dollar, and from this point the pains radiate in all directions. Headaches, neuralgia, renal colic, cystitis, pains in testicles and spermatic cords, dysmenorrhœa, after-pains, angina pectoris, cough, etc., with pain in the region of the umbilicus, yield kindly to this drug. There is no remedy equal to this in sinking at the pit of the stomach—gone feeling in stomach, also with pyrosis.—*California Homœopath*, March.

**ZINCUM IN DIPHTHERIA.**—Dr. Woodward, says: "In diphtheritis where there seemed no hope I have found zinc to work like magic. It is indicated when the disease, starting in the pharynx, goes down into the larynx, with much infiltration of glands, great pallor, with very feeble and irregular pulse, hands and feet cold, and still more definitely indicated if in addition there is delirium or coma, with severe prostration."—*Medical Era*, March.

**INDICATIONS FOR PULSATILLA AND KALI BICHROMICUM IN GONORRHOEAL RHEUMATISM.**—Dr. Schatt, says: "Pulsatilla for gonorrhœal rheumatism aggravated by warmth, ameliorated by cold and pressure; must move about, no relief from motion; pains erratic. Kali bichromicum, wandering rheumatic pains: pains in small spots, the size of a ten-cent piece; always better from warmth."—*Medical Era*, March.

**PROVING OF ANTIPYRIN.**—Dr. Cordelia Williams sends to the February *North American Journal of Homœopathy* the following symptoms occurring in a patient, unmarried, blonde, age twenty-eight. She had been feeling badly all day; headache over left ear, on top of head and through left eye. Dissolved ten grains of antipyrin in half a gill of water and took it. Sat down and happened to draw a celluloid instrument across the upper teeth near the gums. Suddenly a most peculiar feeling, like the sensation caused by trying to eat during an attack of mumps, followed the course of the instrument across the gums, shot down each tooth, then went to lower gum and lip, thence under the tongue, down the throat, over the roof of the mouth, and down the glands on the outside of throat. Sneezed violently, felt flashes of heat, alternating with chills, and broke out in a perspiration. There was a terrific pain in upper part of stomach, going upward. Head, face and neck became terribly suffused, the nose purple and swollen, the upper lip swollen and stiff. She thought she was paralyzed and dying. The ears itched, tingled and bled. Tingling and itching all over the body; finally, white spots appeared in red patches, became very numerous and confluent. The urticaria appeared first on abdomen and hips, chest and throat; then on arms and thighs: not severely below knees, and lastly on fingers and toes. The anguish abated as the urticaria developed. Eyes became suffused, and red spots appeared before them. Felt drowsy but could not sleep. Felt as though she were leaving her body, with all sorts of confused ideas; weak and nervous. The urticaria disappeared in two hours, and two hours afterwards the hands still tingled, and they tingled next morning, with pain in the right arm extending from below the elbow to the second and third fingers. There was a slight, watery leucorrhœa. The head was not cured, but the pain was rendered somewhat easier.

**AURUM MURIATICUM IN SUPERFICIAL ULCERATION OF THE CORNEA.**—Case of old, obstinate superficial ulceration of the cornea, with moderate photophobia, redness and lachrymation. The patient had a cough, and the general circulation was

poor; would not react to various remedies. Patient made a rapid recovery under *aurum muriaticum* 3. Have frequently observed favorable results from this drug in chronic ulcerations of and limited infiltrations into the cornea. The local symptoms are not especially characteristic. The bone pains may be present, especially with the scrofulous or syphilitic dyscrasia. Mental depression always suggests the drug.—Dr. George S. Norton, in the *North American Journal of Homœopathy*, February.

**ALLIUM CEPA IN CILIARY NEURALGIA.**—Dr. Liebold first recommended this drug, in five-drop doses of the tincture, for ciliary neuralgia occurring after cataract-extraction. I have used it in this class of cases with most favorable results, and have extended its use to other forms of ciliary neuralgia. In a recent case of irido-choroiditis of the right eye relief was obtained only from allium. The inflammation began in the iris, with usual symptoms of contracted pupils, discoloration of iris, ciliary injection, and considerable pain, worse at night. Under atropine, the pupil was kept dilated from the beginning, but the inflammation progressed until the chemosis became excessive, the eyeball very sensitive to touch, the aqueous and vitreous humors so clouded that the fundus could not be seen; the vision was lost, and the pain in the eye, extending to the whole head, worse on the right side, and aggravated at night, became so severe that he was almost beyond control. His nerves were completely shattered from pain and loss of sleep, and I feared that the eye was lost. *Allium cepa*, in five-drop doses, was at last given, with most rapid relief from pain. It also seemed to exercise a favorable influence upon the inflammation, so that under this drug, and thus toxicodendron, the patient made a rapid recovery, with complete restoration of vision.—Dr. George S. Norton, in the *North American Journal of Homœopathy*, February.

**GELSEMIUM, JABORANDI, PHYSOSTIGMA AND ESERINE, IN SPASM OF THE ACCOMMODATION.**—Dr. George S. Norton, in the *North American Journal of Homœopathy* for February, relates the following case: A young lady, about twenty-five years of age, had myopia, 1.25 D. in right eye, 1 D. left eye, with frequent severe headache on one side or the other upon any use of the eyes. Under gelsemium the headaches were relieved, and the myopia diminished to 0.75 D. right eye, 0.25 D. in left eye. Similar results have been obtained in other cases. Dr. A. C. Peterson, in the *O. O. and L. Journal*, first suggested its use. Jaborandi is, I believe, more often indicated in spasm of the accommodation than gelsemium. In the former we have, with the spasm of the ciliary muscle, a twitching of the lids but not the headache, which is usually present when gelsemium is called for. Physostigma and eserine are very similar in their action to jaborandi, and it is often impossible to differentiate them.

**GELSEMIUM IN HEADACHE, WITH IRREGULAR ACTION OF THE OCULAR MUSCLES.**—Eyes tire upon reading or using in near vision; often with pains in and around eyes. Accompanying the asthenopic symptoms, there will usually be more or less dull headache over eyes, to vertex and in occiput, worse upon the right side. These symptoms have been verified in a large number of cases. Onosmodium is very similar in its action to gelsemium, except that the former is more often required when the symptoms are more pronounced in and around the left eye, and in the left side of the occiput, and frequently accompanied with vertigo.—Dr. George S. Norton, *North American Journal of Homœopathy*, February.

**A POSSIBLE REMEDY IN ANGINA PECTORIS.**—Immediately after being stung by a scorpion, the individual has an intensely-acute pain in the heart. The poison ought therefore, if potentized, to be a valuable remedy in angina pectoris.—*North American Journal of Homœopathy*, February.

**CHAMOMILLA IN HEPATIC COLIC.**—Dr. Terry has frequently used chamomilla with success in hepatic colic. The French physicians use it greatly in rheumatism when the neuralgic element predominates.—*North American Journal of Homœopathy*, February.

**COTOIN IN DIARRHŒA.**—Dr. Terry's indications for cotoin in diarrhœa are painless stools, followed by tenesmus, the stools being bilious in character. He has cured with it in the third trituration, when croton tiglium failed in this trouble.—*North American Journal of Homœopathy*, February.

**INDICATIONS FOR TABACUM IN MENIERE'S DISEASE.**—Labyrinthine vertigo, with feeling as if sea-sick.—Dr. Terry, in the *North American Journal of Homœopathy*, February.

**INDICATIONS FOR TABACUM IN SEA-SICKNESS.**—Heat along the spine, from the nape of the neck down, cold perspiration, then vomiting.—Dr. Terry, *North American Journal of Homœopathy*, February.

**GELSEMIUM AND IGNATIA IN AFFECTIONS OF CIGAR-MAKERS.**—Dr. Terry, who has been practicing for twelve years in Cuba says that impotence, palpitation, and dyspepsia, with pyrosis are frequently observed. The best remedies are gelsemium for the neurotic symptoms and ignatia for the gastric ones.—*North American Journal of Homœopathy*, January.

**REMEDIES IN SYRINGOMYELIA AND OTHER NERVOUS DISEASES.**—Dr. Samuel Lillenthal, in the February *North American Journal of Homœopathy*, in a translation of an article on "Syringomyelia," by Charcot, remarks upon the dearth of old-school therapeutics for the disease, and suggests a study of the following drugs:

*Arnica* is our chief absorbent. We read in its pathogenesis much of faulty nutrition; fibrillary twitchings; intermittent tearing in almost every part, especially in limbs; mostly rising from below upwards; tendency to degeneration of tissues; pain in last cervical vertebra on bending, with tension; twitching pains from left shoulder to middle finger; arm weary, as if bruised; weakness of the cervical muscles, they do not support the head; ends of fingers cold, heaviness in limbs; exudations in brain and spine.

*Argentum Nitricum.*—Paralysis from spinal affections, with great exhaustion and restlessness; mental depression, without desire to do anything; paralytic drawing pains in arms, which feel heavy; numbness of finger tips; debility and weakness of lower limbs, with sick feeling, dread of work, drowsiness, chilliness and sickly appearance; emaciation, with paralytic weakness; incipient paralysis.

*Esculus Hippocastanum.*—Lameness and weariness in neck; aching between shoulder blades; spine feels weak; backache in cervical, lumbar and sacral regions, and from motion; aching and sensation in left acromion-process, with shooting down the arms; arms and hands numb as if paralyzed; cracking of the skin of the hands; formication.

*Arsenicum Album.*—Progressive muscular atrophy; violent neuralgic tearing pains in upper and lower extremities; formication along spine, paralytic feeling in upper limbs; hands and lower forearm hard; vesicles filled with blood on tips of fingers; ulcers and scabs under nails; nails discolored; heaviness of limbs; exhaustion from slightest exertion; emaciation, skin of legs cold and flaccid.

*Calcarea Ostrearum.*—Spinal paralysis; rheumatic pains in upper cervical vertebra, with stiffness of neck; scoliosis; muscular atrophy, with painful aching of muscles of shoulders and arms, and weariness, as if paralyzed; painful nodules on fingers; boils and rhagades on hands and fingers; marasmus, with glandular swellings of scrofulous subjects; leucophlegmasia.

*Cuprum.*—Motor paralysis, with atrophy and contractions, ascending from periphery to centre; spinal irritation, with violent paroxysmal pain and extreme sensitiveness of whole spine.

*Graphites.*—Numbness and dead coldness of the fingers and arms; smarting, cutting as from an ulcer in lower cervical vertebra; emaciation without visible cause; paralyzed sensation in upper and lower extremities; chronic eczema; finger and toe-nails rough and discolored.

*Lathyrus.*—Motor paresis, with tremulous, tottering gait, with great emaciation; tendon reflexes exaggerated; neither pain nor atrophy.

*Nux Vomica.*—Multiple sclerosis; spinal irritation, with loss of power in extremities; formication along spine; parts cold, numb, emaciated; paresis of arms, with violent jerks as if the blood would start out of the veins.

*Oxalic Acid.*—Sclerosis of posterior column, pains shooting down from cord to lower extremities; jerking pains, confined to small spots; extremities livid and cold; nails dark and fingers contracted; petechiæ; reflexes increased.

*Phosphorus.*—Progressive spinal paralysis, with partial contraction of the affected muscles; formication and tearing in limbs; anæsthesia; spinal irritation, with burning pains between the shoulders; scoliosis from caries of the vertebræ; nails hard and dry; weakness and heaviness of the head and feet, finally paralysis; ulcers that will not heal about the nails.



**Phyostigma.**—Excessive spinal congestion, intellect remaining normal; pain in nape, reaching to first dorsal vertebra; weakness in whole spine, with inability to stand erect; neuralgic stitches in muscles of the arms and legs; crampy pains in hands; sudden jerking of limbs when going off to sleep.

**Pieric Acid.**—Degeneration of the spinal cord; tired feeling on least exertion, with indifference to anything around him; bereft of will-power; disposition to boils, showing degeneration of blood.

**Plumbum.**—*Cerebro-spinal sclerosis, hence progressive muscular atrophy* (a necessary sequela of gliomatosis); wrist-drop; extensors more affected than flexors; emaciation; trembling of hands and feet; backs of hands blue, clammy, infiltrated; nails bluish-gray; intense reflex excitability; hyperæsthesia; vesicles; boils; gangrene.

**Secale Cornutum.**—*Anæsthesia and paralysis*; epileptiform spasms; burning inside and icy-cold objectively; numbness and crawling in upper and lower extremities, with tendency to gangrene.

**Silica.**—Malnutrition, herpetism, with tendency to suppuration; emaciation, with pale, suffering expression; stiffness of nape, with headache and chilliness; nails gray, dirty, splitting in pieces; paralysis of hands, with atrophy and numbness of fingers; felons and glandular swellings.

**Sulphur.**—Paralysis, resting on a material basis; general weakness of spine, which is tender to pressure, so that he walks stooping; hysteria, with jerkings and convulsions; emaciation; bruised pain and tension in nape of neck, paralytic sensation in nape; painful drawing in nerves, extending to wrists; cold hands and feet; or heat of the palms and soles at night.

**Tabacum.**—Morbid feeling in different parts of spine; if in cervical or cervico-dorsal region, depression and paralyzed sensation of forearm and hands, with compression of manubrium sterni; hands seem paralyzed and cold; formication.

**NUPHAR LUTEA IN SEMINAL EMISSIONS AND SEXUAL WEAKNESS.**—"Dr. Petis, who proved the remedy, reports a number of clinical cases where he employed *nuphar*. One of these was 'a patient convalescing from typhoid fever, whose feeble state was aggravated by nocturnal emissions.' These gradually diminished and disappeared under a few doses of *nuphar* 6, for several evenings. Another case reported was that of a man who for nine years had suffered from involuntary seminal losses during sleep, at stool and when urinating; he was pale and languid; he took *nuphar* (strength not stated) two doses a day, for thirty days. 'His paleness diminished, his general weakness disappeared by degrees, and his digestive functions took a new start; at the same time the pollutions ceased, erections came on, accompanied by a decided propensity for the generative act, and before the thirtieth day of the treatment he was able to satisfy it with success and without fatigue.'" —*Homœopathic Recorder*, January.

**NUPHAR LUTEA IN THE SEXUAL SPHERE.**—"This old remedy, the yellow pond lily, is worth considering with reference to its action on the sexual organs. It is claimed for *nuphar*, by the eclectics, that it allays abnormal sexual excitement and irritation, is valuable in spermatorrhœa, and, in strong doses, controls satyriasis and nymphomania, and will often cure prostatorrhœa after other remedies have failed."—*Homœopathic Recorder*, January.

**CHRY SOPHANIC ACID.**—A very interesting paper on this drug was read before the American Institute of Homœopathy. Chrysophanic acid is an extract of goa powder, a substance found in the wood of a Brazilian tree, and long used in South America for skin diseases. A professional friend of Dr. Beebe, who was troubled with marginal blepharitis, while preparing some of this drug for external use—one part to ten of vaseline—applied a little to his eyelid. The effect was immediate: "Marked conjunctival inflammation of the globe and lid, contraction of the pupils, with intense photophobia, the least ray of light producing great pain, which was intensified by a throbbing sensation, synchronous with the action of the heart; this was accompanied by phosphorescent flashes of light, like that from the application of a galvanic current. On forcing the eye to look at objects in the darkened room, retinal impressions of them were left or retained for some time after closing them. There was swelling of the lids and irritation of the skin about the eyes." This continued about a week, after which there was a marked improvement, and another and milder application effected a complete cure.

The remedy seems best adapted to that variety of the disease known as blepharitis ciliaris, and should not be used in greater strength than one part of the powder

to a thousand of vaseline, for fear of aggravations. It is not, however, in affections of the lids that the doctor has been most pleased with its action, or where it promises to be of the greatest service. The array of symptoms brought out by the proving, gives us a most complete picture of retinal asthenopia, or, as Græfe called it, retinal hyperæsthesia, a condition which is difficult to cure, and for which we have but a limited number of remedies. In its action upon the retina, iris and ciliary body, it is an analogue of physostigma and pilocarpinum, and should prove of equal value in affections implicating those structures, when its sphere of action shall have been clearly defined by thorough provings. It will, undoubtedly, prove of greater value when administered internally, and used as a collyrium in overtaxed eyes, than as a myotic, as its action is too violent when used in sufficient doses to produce its characteristic effect upon the pupil. I have given internally in the third decimal in photophobia, attending scrofulous ophthalmia, trachoma, keratitis and iritis with seeming good effect, but I believe it more applicable to those of retinal asthenopia, which are caused by undue irritation of the ciliary system from straining the eyes, either by an intense or insufficient illumination.

Dr. A. B. Norton said: "I have used chrysophanic acid with success not only in blepharitis but also in conjunctivitis and keratitis of the phlyctenular variety. I have also used it in cases of eczematous conditions behind the ears. I use it locally as well as internally. I have not found any aggravation from its local use, and I have employed an ointment of the strength of eight grains to the ounce."—*Homœopathic Recorder*, January.

**THE COUGH OF BROMINE.**—In bromine there is a loose, rattling breathing, and it seems as if the next cough would bring up a quantity of mucus, but when the cough comes it is dry and hard. This is a symptom which I have verified repeatedly, especially in croup, also in diphtheria, when the membrane is breaking up. There is a cool, sweaty skin and no fever. In this I am somewhat at variance with some of your text-books.—Dr. Allen, *Chironian*, January.

**BARYTA MURIATICA.**—I do not know that the action of baryta muritica is thoroughly known among surgeons. Were a man to come into my office with fibroid degenerations of the walls of the arteries and danger of aneurism forming, or, if an aneurism had already developed, I would put that patient on baryta muritica to check the general degenerative process, and with a good chance of curing the existing tumor.—Dr. Allen, *Chironian*, January.

**BELLADONNA, CHAMOMILLA AND CICUTA IN CONVULSIONS.**—Dr. Moffat says three remedies meet most cases of convulsions: Belladonna, where the convulsion comes without warning, or it may be preceded by jumping and starting in sleep. Chamomilla, where it follows a passionate outburst of rage. Cicuta, in frequently recurring convulsions, opisthotonos, pale face, dark rings around the eyes, and cerebral anæmia.—*Chironian*, January.

**VALERIANATE OF ZINC IN HYSTERIA.**—Farrington says of this drug that he does not remember to have failed to cure in a single instance what has been generally termed the fidgets in hysterical and nervous persons. They cannot keep still, or they must keep the legs in constant motion.—*Journal of Obstetrics*, January.

**VALERIANA AND ITS CONGENERS IN HYSTERIA.**—The January *Journal of Obstetrics* says that Dr. Farrington wrote a valuable summary of the comparative indications of valeriana and those medicines which approach that drug closely in their relationship to hysteria.

*Moschus.*—Excited, scolding, fainting; coldness; spasm of glottis and lungs.

*Castoreum.*—Exhausted, pains better from pressure; menstrual colic with pallor and cold sweat.

*Nux Moschata.*—Errors of perception, drowsy; faints; enormous tympany; oppression of heart to throat; skin cool.

*Valeriana.*—Nerves irritated; cannot keep still; tearings, cramps, better when moving; taste of tallow or slimy.

*Asafoetida.*—Reverse peristalsis, rancid eructations, offensive flatus; tightness of the chest; checked discharge.

*Magnesia muritica.*—Faints at dinner, relief from eructations; head better from pressure and wrapping up; palpitation, better on moving about; stools crumble.

**PETROLEUM IN ECZEMA.**—Dr. Walton advises petroleum 30x for eczema about the perinæum and inner sides of thighs with constant desire to scratch.—*Medical Era*, January.

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MEDICINAL TREATMENT IN CASES OF OBSTINATE VOMITING OF  
PREGNANCY.

BY DR. PIERRE JOUSSET, PARIS, FRANCE.

(Translated from L'Art Medical by S. Lillenthal, M.D., San Francisco, Cal.)

THE various uterine lesions that are credited with being the cause of obstinate vomiting during pregnancy often exist in patients who have no vomiting, so we must believe them to be coincident complications, and not the cause of the disease. For this reason I do not favor local treatment of these cases, but rely upon medicinal treatment. Here, as in any other disease, strict individualization is necessary, as its neglect will lead to failure.

*Nux vomica* is preferable when the vomiting occurs in the morning, and is associated with obstinate constipation. The patient vomits very sour mucus with bile, accompanied by excessive pains in the epigastrium, by gastralgia, worse by motion, and relieved by the horizontal posture. *The patient never vomits her food.* The more severe the pain, the higher should be the potency employed. As individual susceptibility varies considerably, there may be cases in which one must resort to the mother tincture.

*Ipecacuanha* is called for when nausea predominates, and salivation is continuous. The patient vomits her food; though she may complain of constipation, she more often defecates easily, or even has diarrhoea. The first trituration is the preparation I would recommend.

Under *ferrum* the vomiting of food takes place immediately after eating it, and is associated with copious mucus vomiting, particularly

in the morning before breakfast; there are also pharyngeal spasms and pyrosis.

The *pulsatilla* patient has continued nausea with disgust for fat and abhorrence of drinks. She has great desire for acids; vomits bitter or sour mucus, especially at night, or the food taken some time preceding. She always complains of chilliness. Both this remedy and the preceding one I should advise in from the sixth to the twelfth dilutions.

*Iodium* is indicated when the vomiting is incessant, the vomited matters consisting of food and bile. There is gastralgia, the pains being of a lancinating, throbbing or burning character. There are also habitual salivation, constipation or diarrhoea, emaciation, jaundice. The old school use this drug in the form of the tincture.

*Kreasote* has nausea with salivation, and chills all over the body. The vomiting occurs before breakfast, the matters ejected consisting of water and slime; thirst and cold hands. The lower dilutions should be used.

*Arsenicum* is called for in advanced cases when the vomited matters consist of bilious green or brown matter. The vomiting is renewed by the smallest quantity of food or drink, and by the slightest movement. There are excessive sensitiveness at the pit of the stomach with burning pains rising up into the œsophagus, anguish, agitation, dry tongue, feeble and small pulse, prostration, sticky sweat, short chills and rapid emaciation. From the sixth to the twelfth triturations.

*Veratrum album* has violent vomiting accompanied by thirst, chilliness and chills; great anxiety and violent pain in the epigastrium with sensation of oppression renewed by taking food or drink, followed by cold sweat and fainting; continual nausea between the intervals of vomiting, with free flow of saliva and strong craving for food. It may be used from the tincture to the sixth dilution.

*Plumbum* is indicated for extremely violent, continuous vomiting of sticky mucus, resembling the white of an egg, sometimes thrown off alone or mixed with the food; obstinate constipation with colic relieved by pressure; jaundice. Opium supports the action of lead, so that I am in the habit of using plumbum 30 in alternation with opium 6. It is better to give these remedies dry on the tongue.

After hypodermic injections of morphia vomiting sometimes sets in, so this drug may be thought of in the constant nausea with excessive malaise, fainting cold sweat, complete moral and physical prostration, reminding one very much of sea-sickness. The drug

should be administered in the form of injection, one or two milligrammes twice daily. Even this small dose may cause an aggravation, in which case it must be still further reduced. In case of amelioration of the symptoms it should be discontinued.

In particular cases graphites, belladonna, aconite, sepia, cocculus, lachesis, platina, or staphysagria may be indicated. In many obstinate cases it is more advisable to change the dose than the remedy, or even to suspend medication for several days at a time. The latter course may be followed by decided improvement.

Dietetic precautions must be observed. Solid food must be strictly forbidden, and liquids only taken in minimum doses, as diluted milk, mild beef tea or chicken broth, changing about from one to the other ; a teaspoonful every half hour. She may drink Vichy-water or take pellets of ice five or six times during the day. Gradually the quantity taken may be increased, as soon as the stomach is able to bear it. Small quantities are often retained when larger ones are ejected, and patients, obliged to lie in bed, do very well on the smallest quantities of food. Exceptionally one meets women who retain alcoholic beverages.

#### REMARKS BY THE TRANSLATOR.

In my repertory I find some other remedies which did me good service and which I have included in the third edition of my *Homœopathic Therapeutics*, to be issued shortly. Of those mentioned incidentally by Jousset, I have great confidence in *staphysagria*, as it suits women sensitive to mental and physical impressions. Among its symptoms we find : Weakness in the morning in bed ; limbs pain as if bruised and as if there were no strength in them ; constant accumulation of water in the mouth ; great desire for alcoholic stimulants ; ravenous hunger, especially for soups, even when the stomach is full. It is the remedy for such neurasthenic women who may vomit other food, but retain their whiskey or brandy.

Burdick and Moffat have great confidence in *symphoricarpus*, and recommend it for qualmishness in stomach with indifference for food ; deathly nausea, violent retching, continuous vomiting ; disgust at the sight, smell or thought of food. There is no proving of it to my knowledge and a very scanty one of *symphoricarpus*.

Look out for albuminuria in pregnant women who vomit, a wise hint which may lead us to study *oolchicum*. She cannot stand erect or lie down with stretched out legs without vomiting ; she has to flex knees and crouch together for relief ; faint aching about navel,

as if she must eat, but with loathing and disgust at the thought, sight or smell of food ; all attempts to eat cause violent nausea and vomiting ; extreme prostration and tendency to collapse, with internal coldness (*veratrum album*) ; watery diarrhœa.

The same disgust for food we meet in *laurocerasus* and *hydrocyanic acid*. Nausea in the morning with hunger, yet food nauseates her ; dry mouth and thirst, clean tongue, hiccough, loss of appetite, nausea and vomiting with violent pains in stomach with feeling as if the stomach were full of water, sometimes with faintness ; frequent diarrhœa of green mucus, with suffocative spells about the heart ; loss of speech ; *petroleum* is applicable to all gastric troubles of pregnant women ; nausea all day, in the morning with accumulation of water in the mouth ; nausea, like that of sea-sickness ; violent hiccough and violent vomiting ; cardialgia with feeling of coldness in stomach and abdomen ; diarrhœa only in daytime ; profuse collection of fluid in the mouth with frequent spitting and nausea (*jaborandi*, *lobelia*, *iris* and others : salivation).

*Conium*.—Nausea only or worse when lying down ; terrible nausea and vomiting in women suffering from scirrhus uteri ; spasmodic contraction of stomach and œsophagus, as if a round body ascended from the stomach ; the vomited matter looks like black coffee-grounds ; constipation alternating with diarrhœa.

*Asarum europ.*—During the first months of pregnancy the stomach rejects everything ; constant nausea with loathing of food, with a perfectly clean tongue ; retching increases in violence in proportion as it becomes more frequent, and all other symptoms are aggravated, only the stupid feeling in head remains the same ; vomiting with anguish and desire for alcoholic drinks (staph.) ; diarrhœa, strings of odorless mucus pass from bowels ; constant chilliness, even in a warm room ; hyperæsthesia of the nerves.

*Lilium* and *sepia* act sometimes promptly where the vomiting is produced and kept up by malposition of the pregnant uterus, but there are cases where they do fail to rectify the malposition and mechanical reduction stops the vomiting promptly. While in *lilium* we mostly deal only with a functional malposition, it may arise in *sepia* from a hard tumefied cervix and before pregnancy set in there were already uterine anomalies with obstinate yellowish or purulent leucorrhœa.

Jousset's proposition of relieving this incoercible vomiting of pregnant women with morphine deserves our fullest consideration, for we read among its symptoms : Aversion to food, burning thirst ;

nausea mornings when rising, better lying; constant retching, faintness, vomiting of scanty frothy liquid, of bile; pain in epigastric region; frequent watery diarrhœa or constipation; creeping chills; emaciation and prostration with melancholy.

“*La clinique*” (which means experience gained at the sick-bed), says the celebrated French physician, “is my authority for alternating plumbum 30 with opium 6th, and the same experience has shown me that this combination works more safely than when either one is given alone. If we only knew the drug which combines the action of both (*Weshe’s puncta dolorosa*), such alternation would become unnecessary.” Constant nausea, constant vomiting of everything taken into the stomach, with violent cramps, retraction of abdomen with hard knots over its surface; constipation with terrible spasms, pulling the anus upwards or blackish scanty diarrhœa are keynotes enough to lead our attention to lead as a suitable remedy, and whether opium is always necessary as a concomitant must be left to the study of the physician. When Jousset prefers the 30th in such cases, might we not feel encouraged to go higher to reach our purpose?

May none of us ever feel the necessity of producing abortion in order to save the mother. Though the law justifies such murder, it is better that two or three physicians meet in consultation to consider the necessity of such a procedure.

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## THE ALBUMINURIAS OF PREGNANCY.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

### TREATMENT.—(*Concluded.*)

AFTER the third month of gestation, collect and measure the urine of twenty-four hours, comparing night and day, in the manner described in the first part of this article. Take the specific gravity of the twenty-four hours’ urine, estimate the solids, urea, phosphoric acid, and compare results with tables already given. If the percentages are all, or mostly, in Class A, while, at the same time, albumin and casts are absent, thus far all is well. Repeat the collections as often as convenient, and occasionally test a sample of urine voided after period of greatest exercise.

Suppose now, that, by vigilant attention to the urine, albumin is found, not due to pus, epithelial cells, bacteria, etc.: (a) If the quantity of urine is still within Class A, and there are no tube-casts; if the total solids, ureas, and particularly phosphoric acid, are in Class A, or high up in Class B, especially relatively, the ordinary precautions to guard against fatigue and excitement, the avoidance of draughts and exposure to cold, care in regard to diet and drinks, together with promotion of free action of the skin by use of warm baths, and regularity in attention to the bowels, will probably prove all that is necessary. But, at the same time, when true albuminuria is once noticed, *frequent* measurements and analyses of the urine should be made, instead of merely occasional observations. If the amount of albumin is small, if the urine does not slowly decrease in quantity but rather is stationary, or tends to increase both in quantity *and in quality*, and if ophthalmological examination is satisfactory in results, it is probable that all will be well and that, not as yet, is there any demand for vigorous treatment.

I lay great stress on the importance of estimations of *phosphoric acid*, for the following reasons:

1. I have noticed marked and persistent deficiency in phosphoric acid, absolutely and often relatively, when the quantity of urea was nearly normal.

2. H. Anott,\* of London, Canada, has found the phosphates in the urine diminished, not only in Bright's disease, but in irritation of the nervous system generally.

3. Landois† has shown, by experiments on animals, that the phenomena of uræmia are due more particularly to irritation of the psycho-motor centres of the cortical substance of the brain, notably by creatin.

Is it not reasonable to suppose, therefore, that signs of this irritation may be found early in the urine, in the shape of deficiency of phosphoric acid? Especially, since it is a clinical fact, which I have noted in scores of cases of Bright's disease, that the phosphoric acid is diminished much more in proportion than is the urea.

Suppose, now (b), that not only is albumin found in the urine, but also tube-casts, the patient becomes œdematous, etc. It is now necessary to note very carefully the condition of the urine. The *liver* may be at the bottom of the disturbance, and the renal disorder may

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\* *Canadian Practitioner*, 1887.

† *Die Uræmia*, Vienna, 1890.



be merely a *degeneration* due to an attempt of the kidneys to rid the system of effete material, unduly irritating, and greater in amount than they can manage, without suffering from the strain. The urine, in such cases, presents the following characteristics: Quantity in twenty-four hours diminished (Class B or C); color much higher than normal; specific gravity high, usually above 1025, seldom below 1020; *relative* quantity of urea, grammes per litre, usually *full normal or even increased*, though *total* quantity is diminished; ratio of urea to salts\* full normal, sometimes considerably increased. Albumin abundant, several tenths or more. Casts and cast-débris abundant, but *blood and blood-casts not present*, or at most a few blood-corpuscles only, no blood chemically. As soon as such urine is found, put the patient to bed, and recommend non-nitrogenous or, better still, if possible, a milk diet, especially if the albumin is several tenths or upwards in the Esbach tube. The skin is to be kept active; the bowels open once daily. If the œdema is great, alcohol sweats may be used. The remedies for this condition are *par excellence*: *mercurius corrosivus* and *euonymine*. Merc. cor. 3x should be given during the day, and *euonymine* on retiring at night.. The latter may be given in doses of one-fourth of a grain upwards. Give enough to produce free movement of the bowels the next morning. As a beverage, give the patient plenty of *aerated distilled water*. As I have often shown, and as everybody knows, the solvent power of distilled water is greater than that of waters loaded with various salts. In the lesion we are now describing, the urine contains *too much solid matter in proportion to the fluid*. It is of great importance not to introduce, in the shape of drinks, lime-salts and other irritating substances, as the kidneys are already overtaxed and unduly irritated. *Give pure distilled water, and plenty of it!* Avoid mineral waters, or at least those containing over five or ten grains of solids to the gallon. Pure distilled water can now be had in all the large cities, and, if properly aerated, is a refreshing and wholesome drink.

By following out such treatment as I have outlined, and by treating the incidental symptoms with various remedies already familiar to all, we need not despair of bringing the case to full term, and saving the life of both mother and child. Suppose now that in spite of treatment the color of the urine grows gradually paler than normal, and the *quality* of the urine becomes inferior, specific gravity

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\* Assuming urea is to salts as 1.25 or 1.33 is to 1.

much below normal, urea relatively now in class *B* or *C*, phosphoric acid relatively less abundant than urea, while albumin is still abundant with casts and cast débris; or suppose that instead of the *gradual* change thus described, there is a *sudden* decrease in the amount of urine—with drowsiness, ringing in the ears, photopsia, dimness of vision, more or less marked, possibly blindness of one or both eyes, dizziness, dyspnoea, especially in exertion, nausea, vomiting, involuntary twitchings and general prostration. Then, and not till then, in my opinion should ideas be entertained of inducing labor. It is not the purpose of this paper to provoke interminable discussion on the subject of induction of labor. It is, nevertheless, well-known that it is possible to carry a patient even through convulsions without inducing labor and, unless the convulsions are often repeated and of violent nature, vigorous treatment may re-establish the function of the kidneys and restore the urinary secretion without necessity for induction of labor at all. I shall not discuss the treatment of eclampsia. The reader is referred to an interesting paper by Dr. William G. Willard in the *Medical Era* for November, 1889.

If the urine presents the characteristics of *parenchymatous degeneration*\* only, while the patient herself is comparatively free from the symptoms of uræmia mentioned above; induction of labor is, in my opinion, not only uncalled for but barbarous. Suppose, on the other hand, that the urine does not at any time during pregnancy exhibit the characteristics of parenchymatous degeneration, but is found to be of poor quality from the start, does not improve in relative quantity of urea and phosphoric acid but retrogrades; albumin and casts are found, etc. In such a case seek for history of puerperal convulsions in previous pregnancy, or of Bright's disease prior to pregnancy. Even if no such history can be had, I am inclined to think with Licorchi that a latent trouble has existed and is now brought to the attention of the patient for the first time. The treatment in such conditions is substantially the same as to hygienic details as before, but there is not so much hope of carrying the patient through. Moreover, too active treatment may now precipitate convulsions, as the urine shows its deficiency in solids, in grammes to the litre or grains to the fluid ounce. The patient may have no dropsy at all, and the nephritis appear to be pursuing a mild course. But obstinate deficiency of phosphoric acid (grains to the fluid ounce)

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\* In the modern sense of the term: urine high-colored, of high specific gravity, no blood, etc.

will be found in analysis and any sudden decrease in quantity of urine will be followed by eclampsia. It is to such cases that I think Dr. Tyson's conclusions as to induction of labor particularly apply.

Lastly (*d*) there is still another class of cases in which the course of the disorder is somewhat different. I refer to those in which *pus* is found in the urine. It has once or twice fallen to my lot to examine urine presenting more or less the characteristics of acute parenchymatous degeneration, except that no casts were to be found. In a few days, however, a layer of *pus* was visible. Puerperal cystitis and pyelitis often occur, and if unaccompanied by disorder of the parenchyma of the kidney, are not, so far as I am aware, especially dangerous. But it is possible that an acute infective process in the kidneys may start from inflammation in the urinary passages elsewhere. In such cases the urine becomes greatly decreased in quantity, of a foul odor, contains several tenths of albumin, the specific gravity is 1015 or below, and deficiency both absolute and relative in urea and phosphoric acid, is noticed. The sediment contains *pus* and blood, plugs of *pus* are found, micro-organisms are very abundant; in some cases it is possible to find bacterial casts. It is likely that in the cases I have seen some chronic inflammation of the lower urinary passages existed prior to the pregnancy, and that an acute infective process developed during pregnancy. This condition must not be confounded with that in which we find a layer of *pus* in the urine settling well, with clear urine of fairly good quality and normal odor above it, or with mere cystitis alone in which we find urine of fair quality as regards solids, allied with an ammoniacal odor, alkaline reaction, etc., but little albumin or trace only. When a suppurative nephritis is developed the condition of the patient on the one hand becomes serious, and the urine on the other hand becomes of notably poor quality, the relative deficiency of phosphoric acid being especially marked. It is difficult to find casts, but if the urine be decanted repeatedly it is sometimes possible to find bacterial casts.

The prognosis in these cases is gloomy. Such remedies as *terebinth*, *eucalyptol*, etc., may be thought of and may perhaps restore the urinary secretion. As a rule, however, they terminate fatally. Fortunately, however, they are not of very common occurrence.

## FIVE CASES IN CEREBRAL SURGERY.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

THE following cases in cerebral surgery are reported in full, because the subject of cerebral localization and its surgical applications is yet in its infancy. But a comparatively few operations in this newly opened field have yet been performed. It is, therefore, incumbent upon every neurologist and every operator to report all their cases, giving equal prominence to their successful and their unsuccessful ones. While successful cases teach much, sight must not be lost of the fact

FIG. 1.

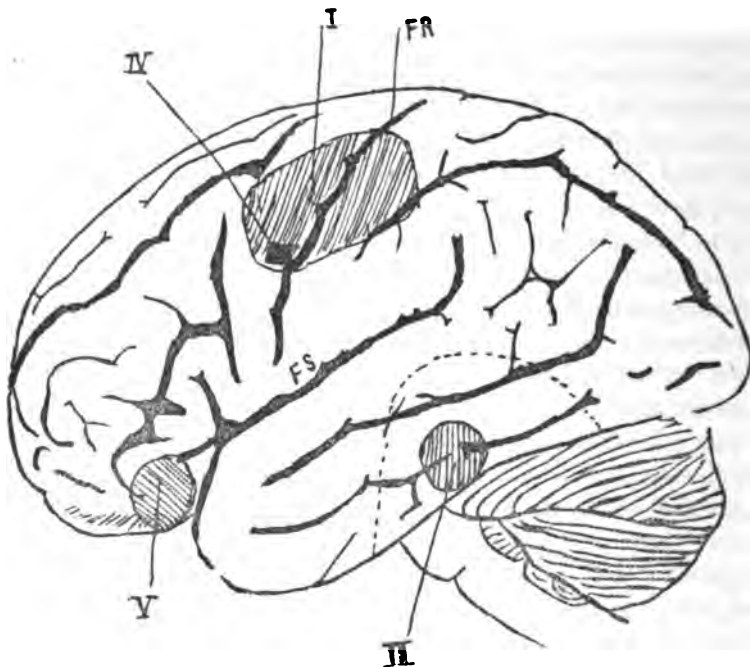


Diagram intended to show the seats of operation in cases I., II., IV. and V. FR, the fissure of Rolando; FS, the fissure of Sylvius; I, the tumor in case I.; II, the location of the abscess in case II.; the dotted line in the temporo-sphenoidal lobe is intended to show the area of softening surrounding the abscess; V, the seat of trephining in case V.

that the unsuccessful are just as instructive. We should certainly learn to profit by our failures.

It was not expected, when this paper was projected, that it would take up the space that now seems necessary. In fact when the great

length to which it would go became evident, I almost felt like abandoning it. The reports of the cases could not be abbreviated in the least, for every datum is necessary in the framing of the diagnosis, the forming of the conclusions which guided our course. As a further apology, I would say that each case, of itself, furnishes a text for a paper; in fact, I may say, that the communication here presented may be regarded as five papers brought together in one.

CASE I.—*Large Sarcoma of the Dura Mater over the Motor Area; Operation; Death on the Third Day.*\*—Mrs. M., a patient of Dr. Claude R. Norton, was seen in consultation on January 13, 1889. An examination gave the following history: Previous to January 23, 1887, she considered herself a well woman. In fact, at that time she was feeling better than she had for some time past, and was gaining in flesh; but on that day after preparing the dinner and while lying down for a rest, she was disturbed by contractions of the fingers of the left hand. The trouble began with numbness of the little finger, which then extended to the adjoining finger, and then up the side of the hand to the muscles of the forearm; then came the spasmodic movements of the hand spreading up the arm, drawing that member up. Then she became unconscious. She did not have another spasm for five days, and then the second was an exact repetition of the first one. She has had numerous other attacks since then, in some of which she did not lose consciousness. One of these convulsions was aborted by her daughter taking hold of the arm and forcibly straightening it. After these convulsive seizures in January, 1887, she had an attack of follicular tonsillitis, followed by considerable rheumatic pain in the left arm and hand; in fact that member was badly crippled by rheumatism. Next she had asthma. Later, an eruption appeared on the lower extremities, and was diagnosed by Dr. Norton as erythema nodosum. Then the asthma reappeared, but yielded finally to iodide of potassium. In March, 1887, the left leg became involved in the convulsive movements. Between the attacks it was also noticed that that member had lost some of its power, for it was dragged in walking. The parietic condition of the leg soon disappeared, for during the following summer she regained its use, as she did also that of the hand, which had also lost considerable of its power after the convulsions referred to. Still the improvement in the muscles of the hand was never sufficient to enable her to use it in sewing. In the fourth convulsion the muscles of the face contracted so severely as to produce ecchymoses. This was the only time the face was involved in the movements until March, 1888. Since the last-named date, the convulsions have recurred at irregular intervals, the longest being five or six weeks. Between August, 1887,

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\* This case was reported by Dr. C. M. Thomas in the *Transactions of the American Institute of Homœopathy*, 1889.

and March, 1888, she had but one attack, and that a slight one, in February, 1888. Her general health during all this time remained good. During the year that has just passed, her general health has been bad. She has lost flesh and has broken down generally. The loss of power in the left hand has been increasing, as it has also in the foot and leg. Headaches began almost immediately after the first spasm, and have continued ever since, and have required frequent doses of antifebrine for their relief. They have generally been accompaniments of the attacks. Sometimes they follow the attacks. There have been times when the mental condition of the patient has been impaired. For awhile her speech was not clear, and Dr. Norton was inclined to suspect that aphasia was about to set in. In writing her hand was tremulous and she would often repeat the same word several times. She is right-handed. She has never had any trouble whatever with the urine, and all the examinations of it, made by Dr. Norton have failed to show that it contained either sugar or albumin. She has never had any bilateral convulsions. She has had, what in her case has been called double ideas. For several months past, she has had tremor of the hands during voluntary movements. Her headaches have been mostly occipital. She had no trouble while passing through the climacteric period. Her pupils reacted normally; she complained of no visual disorder; the fundus oculi was normal. The knee-jerks were excessive, but there was no ankle clonus. A diagnosis of tumor of the brain, situated in the middle of the convolutions on either side of the fissure of Rolando, was made, and an operation for the removal of the same was advised. Owing, however, to the danger involved in such a procedure, and a feeling on the part of the family that all medicinal measures had not been exhausted, this advice was declined, and we were requested to continue our efforts still longer, without the services of the surgeon. Although a history of syphilis was denied, and notwithstanding the fact that the symptoms were such as not to indicate a syphilitic brain lesion, it was decided to try the effect of iodide of potassium. This was then resorted to in large doses. At first but ten grains three times daily, in an alkaline water, were given. This dose was gradually increased, until finally the patient was taking no less than three hundred grains of the drug *per diem*. Under this treatment she thrived apparently, and it really seemed as though she would make a recovery. The improvement proved illusory however, for in May she began to grow worse once more.

On June 9, 1889, I was again called in to see Mrs. M., and this time, Dr. C. M. Thomas also saw the patient, and conducted the examination. The above history was again elicited. The patient was found to have almost complete wrist-drop. This condition existed at the first examination, but was nothing like as marked as it was in the second. There was also decidedly more rigidity of the arm. On attempting to straighten the hand, there was produced a very marked wrist clonus. She was found to have fair power in all the muscles of the upper extremity excepting those of the forearm. A

very marked ankle clonus was obtainable on the left side, but not at all on the right. The plantar reflex was normal on the right side, but absent on the left. There was some asymmetry of the face, owing to slight paresis of the left side of the face. The surface temperature was the same on both sides of the head. No tenderness was obtainable on percussion of any portion of the skull. As before, the pupils reacted normally, and the fundus oculi was normal. She was confined to her bed at the time of the second examination. The diagnosis given in January was reiterated, and the suggestion offered that there was probably also a secondary degeneration of the pyramidal tracts. An operation was again advised, and was readily consented to by both patient and family, and its immediate performance urged. On June 13th, the operation was performed by Dr. Charles M. Thomas. On the morning of the second day preceding the operation, the head was shaved, and thoroughly scrubbed with soap and water. On the morning of the operation the head was again scrubbed, and wrapped in cloths wrung out in bichloride-water, 1:2000, and these were left in place till just before the operation. On the afternoon preceding the operation, Dr. Thomas and myself carefully mapped out the fissure of Rolando, using for this purpose, both Reid's and Horsley's measurements, making a slight scratch in the scalp with a needle to indicate its upper and lower end. Immediately before the operation, confirmatory measurements were made, sterilized tapes and measures being used. No stimulant or morphia was administered, and the patient received no food, other than a little milk, early in the morning. All the instruments were boiled fifteen minutes before the operation, and were immersed directly from the boiler in 1:40 carbolic solution. There were present at the operation, Drs. C. R. Norton, John E. James, W. B. Van Lennep, William W. Speakman, and myself. Dr. Speakman etherized, while Drs. James and Van Lennep assisted Dr. Thomas in the performance of the operation. Without going further into the details of the operation at the present time, it is sufficient to say for the present that on removal of the button of bone by the trephine, a pointed conical projection of bone, three-eighths of an inch long, resembling an old inward displaced fracture-fragment of the inner table, was found. This sharp projection ran through the dura mater, and was continuous with a rather firm pinkish-gray mass of tissue. This mass proved to be the tumor. The trephine opening was enlarged with the Rongeur forceps and by a second trephine opening. The opening now measured two inches and a half in length, antero-posteriorly, and two inches vertically, and still the limit of the tumor could not be felt through the dura in any direction. The dura was then opened, but was found so densely adherent to the surface of the growth, that it had to be scarified in the removal of the same. Further enlargement of the opening brought the limit of the tumor within reach, when it was lifted from its bed, after a little careful manipulation. The bottom of the cavity showed the flattened convolutions, very soft to feel but otherwise apparently undamaged,

either by the pressure of the tumor or by the manipulations required for its removal. The growth measured three and a half inches in length, two and a half in width, and one and a half in depth, and weighed fully three ounces.

The patient did very well for twenty-four hours after the operation. She complained greatly, however, of heat and pain across the forehead, and insisted upon fanning herself. Her mind was very clear, but she was completely hemiplegic on the left side. At the end of the second day she began to grow unconscious, and this condition increased until death took place, exactly seventy-two hours after the operation. Preceding death her temperature was 104°. At the *post-mortem* examination the flap was found united, excepting over the posterior portion, under which had projected the gauze drain. There was no indication of over-inflammatory action, even in the brain membranes. The cavity left by the removal of the tumor was partly filled with blood-clot. About the former location of the growth the brain tissue was softened to a homogeneous mass. This degeneration reached antero-posteriorly from a point opposite the termination of the fissure of Sylvius posteriorly, to the base of the frontal lobe anteriorly, and from the subcortical substance above to the basal ganglia.

So much space has been taken above in the description of Mrs. M's case that it would seem hardly necessary to make any remarks on the same. I think, however, that it would be well to state briefly the reasons that led to the diagnosis of brain tumor and its localization in the area in which it was found.

The attacks of convulsions were plainly those of the so-called Jacksonian type, and being such were indicative of a gross lesion situated in that portion of the cortex of the brain containing the motor centres for the upper extremity. Epilepsy was positively excluded by the age of the patient, the localized character of the convulsions, the preservation of consciousness during the initial movements of the attacks, the post-convulsive paresis, the paralysis, which finally became a constant symptom, and other symptoms pointing conclusively to organic disease of the brain. The nature of that pathological condition being the next problem, it was believed that a tumor existed, because of the localized nature of the lesion and the excruciating headaches from which the patient suffered. As to the nature of the tumor, no opinion was hazarded, though the possibility of its being syphilitic in nature was carefully considered. Not much faith was held in this latter, and an anti-syphilitic treatment would not have been instituted had not an operation been denied; it was our only remaining resource. The absence of optic neuritis was not regarded as of any moment in this case, as it is by no means a con-



stant symptom in cases of tumor of the motor area of the brain. At the time the tumor first made its presence known it was evidently of small size, as shown by the extremely limited portion of the body convulsed in the attacks, namely, the hand. The gradual increase in its size was characterized by just as gradual an increase in the areas of the left side of the body involved in convulsion, until finally the growth had involved the lower limits of the arm and hand centres below, and those for the leg above. The site chosen for the first trephine opening was immediately over what was supposed to be the exact centre of the growth, a supposition that was proven correct at the operation. The finding of the spicule of bone projecting into the dura mater on the under surface of the first button of bone removed led to inquiries concerning previous injuries. It was then that we learned that in childhood she sustained a severe fall on the head. No connection between that accident and the present illness had ever been deemed possible by either the patient or her family, so for that reason it was not mentioned to any of her medical attendants. It was a pity that the operation was not attempted early in the progress of the case, for, inasmuch as the tumor was not in the least adherent to brain substance, its removal when it was yet small must have been a comparatively trivial operation, one, too, that would have resulted in a most brilliant cure. I almost feel that had an operation been performed immediately after my first visit in January that a successful result would have been obtained, for at that time the absence of rigidity, and ankle clonus, and permanent paralysis of high degree showed that descending degeneration of the pyramidal tracts had not yet appeared. It was seen plainly at the time of the *post-mortem* examination that the extent of degeneration in the white substance of the brain was so great as to positively preclude even a possible recovery. The symptoms prior to the operation, and the advanced nature of the degeneration (it being too great to have taken place in the short period intervening between the operation and death), and the failure of the brain substance to fill in the gap left by the removal of the tumor, showed that this degeneration was the direct result of the progress of the growth.

CASE II.—*Chronic Suppurative Otitis Media; Abscess in the R. Temporo-Sphenoidal Lobe; Cerebritis; Trephining; Death.*—John H., æt. 50 years, had been suffering from chronic suppurative otitis media for years. About December 15, 1889, he sent for Dr. A. C. Rembaugh on account of severe head pains, from which he had com-

plained for not less than eight weeks preceding. These pains were very persistent. At that time the discharge from the ears was quite profuse and very offensive. The persistence of the headache led the Doctor to suspect cerebral disease at once, which suspicions were confirmed a day or so later, when the patient became somewhat stupid, and paralysis of the left arm and leg appeared. He then called upon Dr. W. B. Van Lennep to operate. I first saw the case in consultation with Drs. Rembaugh and Van Lennep on December 17th. There was a profuse offensive discharge from the right ear, as above stated; but the most careful examination failed to show any sign of involvement of the mastoid process. A redness over this portion of the head was the only suspicion that such disease existed. The patient had almost a complete paralysis of the left arm and leg. This paralysis had begun in the arm, and had later involved the leg. The face was not affected. His intellect was decidedly clouded. He gave answers to questions with extreme slowness, and then only when the questions were shouted at him. He would then relapse into his stupor. His temperature was normal. Both patellar tendon reflexes were exaggerated, and a well-marked ankle clonus was obtainable on both sides, that on the left being the greatest. The pupils were equal in size and reacted normally. The fundus oculi gave no evidence of any abnormality beyond a slight obscuration of the margins of the disks. A trephining of the mastoid process was decided upon as the proper operative measure at first; in case circumstances warranted it a trephining for the evacuation of a cerebral abscess should afterwards be done. The patient's bowels not having moved for some time, an enema of glycerine was ordered. Silicea was the remedy given. On December 18th the patient was much better, and the paralysis had in a great measure disappeared. He was now mentally brighter, and answered questions readily, though he was somewhat hard of hearing. There was no ankle clonus to be obtained on either side. Owing to the great improvement, operative interference was postponed for the present. On December 19, he became worse once more, and then Dr. Van Lennep cut down upon the mastoid, but finding nothing but a thickening of the periosteum, and a slight softening of the surface of bone at a point where tenderness had been elicited the day before, satisfied himself with simply removing the diseased portions. On December 20th the patient was greatly improved, and this improvement continued for two days, when a relapse into a condition decidedly worse than any that had preceded came on. On December 23d he was removed to the Hahnemann Hospital for operation. It was decided then to open into the mastoid cells, and, if necessary, trephine the skull to get at the supposed abscess. The mastoid was opened, but no disease of it was apparent.

By my advice Dr. Van Lennep then trephined just posterior to the middle of the line on the surface of the skull, marking the position of the fissure of Rolando. The cerebral membranes were found highly congested. There was but slight bulging. A grooved

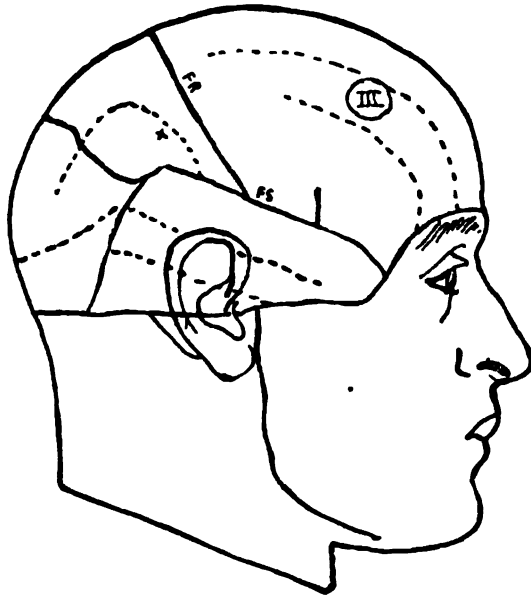
director was then passed into the brain-substance in the direction of the posterior edge of the mastoid until it encountered firm resistance, when it was withdrawn; no pus was evacuated, but the groove of the director was filled with dark blood. The instrument was then passed in several other directions in which an abscess might be found, but with a negative result in each instance, other than the revealing of the highly congested condition of the cerebral substance. The operation was then abandoned. The patient died that night, six hours after the operation.

An autopsy was performed by Dr. Vischer on the following day, in the presence of Drs. C. M. Thomas, John E. James, H. L. Northrup, J. M. Caley, A. C. Rembaugh and myself. The dura mater was found hyperæmic, especially on the right side. The brain was readily removed, with the exception of the posterior portion of the temporo-sphenoidal lobe which was firmly adherent to the bone. After some little difficulty this was separated, when a quantity of thick laudable pus appeared. On removal of the brain, an abscess, about the size of a small hen's egg and containing about an ounce of thick greenish pus, was found at the posterior portion of the temporo-sphenoidal lobe. It had a wall about five millimetres in thickness, and quite resistant. The cerebral substance, for quite a distance surrounding the abscess, was quite softened, in fact almost necrotic. Beyond a general hyperæmic condition, the rest of the brain was normal. A perforation was found on the upper part of the petrous portion of the temporal bone, and along the edge of the petrous ridge, from caries. Pus was also found between the bone and endostium.

My diagnosis, when I first saw the case, was abscess of the brain with cerebritis, in which opinion both Drs. Van Lennep and Rembaugh concurred. Notwithstanding the extent of the hemiplegia, I did not believe that the abscess encroached on the motor tracts, but that it was quite near to the same, and that it had caused the paralysis by reason of exciting inflammation, an opinion that was confirmed by the subsequent periods of improvement. Because the arm was paralyzed in advance of the hand, I argued that the irritation was high up in the course of the contracting tracts, near the cortex, where the fibres for the different portions of the body are more widely separated than they are below. I therefore advised in case the opening of the mastoid proved inefficient as a remedy, that a trephining be performed, the opening to be made posterior to the median portion of the post-Rolandic convolution, and then the grooved director passed through the brain substance from that point towards the base of the mastoid process. The result has already been told. There can be no doubt that the director touched the wall of the abscess, but the denseness of that membrane was such that one was

hardly justified in using force. Had the abscess been evacuated in this situation, it would have been necessary to make a counter-opening back of the mastoid process, as was done by MacEwen in one of his cases; it would never have done to have permitted a long suppurating tract through healthy brain-substance. But had an opening been made over the temporo-sphenoidal lobe, back of the mastoid, and the abscess evacuated from that point, then we would have had an additional complication; not only would the abscess have been emptied, but the semi-fluent brain-substance surrounding

FIG. 2.



A diagram intended to show the lines used for locating the various fissures and convolutions of the cortex. III shows the seat of operation in case III.

it would also have escaped. The cavity that would have thus been formed, would have been something tremendous. I believe death would have ensued sooner in that event.

Another interesting point, in connection with the case, was the almost total absence of mastoid disease in association with the extensive suppurative changes going on in the brain.

A very important point in the surgical treatment of the case, was the question of first trephining the mastoid or not. Green teaches that it is bad practice, when abscess of the brain exists. Keen, on

the other hand, believes that it should always be done, even though subsequent trephining of the skull is necessary, as in the latter case it affords better chances for an aseptic operation.

This case teaches the importance of attention to chronic suppurative diseases of the middle ear.

**CASE III.**—*Dural Epilepsy, Following Injury to the Scalp; Sensitive Depressed Cicatrix of the Scalp; Traumatic Meningitis; Incomplete Hemiplegia; Operation; Recovery.*—S. J. H., æt 63 years, was admitted to the Hahnemann Hospital in the service of Dr. Charles M. Thomas, at whose request I examined him. Mr. H. stated that he was in possession of perfect health up to the time of the accident which disabled him, one year ago. In the accident referred to he sustained injuries in different portions of the body, and, so he stated, a fracture of the skull in the frontal region on the right side. To confirm this assertion there was to be seen a long and somewhat depressed cicatrix, giving all the appearances of being immediately over a depressed portion of bone. He was up and about three or four weeks after the accident. Eight or ten weeks later his present ailment began. The first thing that he noticed was spasmodic movements all over the right side of the body. He states, furthermore, that he also felt these spasms "inwardly." These spasmodic movements consisted of twitchings of various muscles of the head and extremities, almost rhythmical in character, and without any loss of consciousness. They made their appearance first in the face, then spreading to the arm and leg, and in the order mentioned. At the time of the examination the twitching was worse in the head and face than elsewhere, though the arms and legs, particularly the former, were by no means free from it. The twitching was very slight indeed on the left side. He has, however, a stinging feeling on the left side of the body. He complained of a burning feeling starting at the cicatrix and extending down the right side of the head and neck, and down the back. He was unable to lie down, as the pressure against his back and the recumbent posture increased the burning and the twitchings, and he became delirious and finally lost consciousness. One week before admission to the hospital he was seized with convulsions, which were limited to the right side of the body, and lasted with short intermissions for three days. Between the convulsions he regained consciousness. The convulsive movements invariably started in the face. The only aura of which he has any knowledge consists of a "nervous, strained feeling," more marked on the right side of the body than elsewhere. Some time ago he had an attack in which he became unconscious, but whether he had a convulsion or not he does not know. When he recovered himself he found that he was entirely unable to move the right arm or leg. This hemiplegia improved considerably, but since the convulsion immediately preceding his admission to the hospital it has been worse. He now walks with the greatest difficulty; in fact, he

needs assistance to prevent him from falling. His speech is normal, so far as his ability to articulate is concerned, but it was of a character that gave the impression that the patient was suffering from great pain. The scar at the junction of the scalp and skin of the forehead, above referred to, was exceedingly sensitive to the slightest touch, which not only caused the severe burning pain, which he described, but greatly intensified the twitching over the entire right side of the body. From this twitching he was never free, excepting when asleep. Successful attempts to distract his attention from his ailment had no effect in lessening the severity of the movements. No attempt was made to measure the strength of the grasp of the hands with the dynamometer, as he had lost several fingers, and no observation for comparative purposes was considered reliable. His pupils were normal. At the request of Dr. Thomas, Dr. Jessup made an attempt to examine the eye with the ophthalmoscope, but owing to the sensitiveness of the parts about the cicatrix and the spasmodic closure of the eyelids the examinations proved impossible. The patellar tendon reflexes were exaggerated, particularly that on the right side.

The character of the symptoms present in the above case precluded any possibility of giving a definite opinion. The limitation of the convulsions to the right side of the body, and the right sided paralysis which followed the attack, seemed to point almost certainly to the left side of the brain as the seat of disease. Yet the fracture of the skull, which we supposed to exist immediately beneath the depressed and sensitive cicatrix, was on the right side of the head, the same side as the convulsions and paralysis. The likelihood of the cicatrix being the *fons et origo* of all the symptoms was carefully considered, but entertained in part only. The possibility of such a cicatrix causing convulsive movements in the face on the same side was admitted without question, but how it could produce a complete unilateral convulsion succeeded by paralysis, was to us an unexplainable problem. The existence of convulsions on the same side of the lesion was explainable on the supposition that there existed some meningeal irritation immediately beneath the scar. We also asked ourselves the question: "Could there be a lesion produced by *contre coup* on the left side of the brain?" We could find no reason for such a supposition, other than the limitation of the symptoms to the right half of the body.

The proper course to pursue, in my opinion, and in which Dr. Thomas concurred, was to cut down over the area of skull covered by the cicatricial tissue, and, in case a fracture was found, to trephine. In case no fracture was found, it was thought that a tre-

phining might still be indicated owing to the possible existence of a depressed fracture of the inner table of the skull. On January 12, 1890, the patient was brought before the class at the Hahnemann Medical College for operation. A horseshoe-shaped flap, including the cicatrix, was dissected up. This flap was found densely adherent to the surface of the cranium throughout its entire length, small bloodvessels running from it into the bone structure. The line of the scar was exceedingly thin. No evidence of a fracture was to be seen. The patient's condition was so serious, and his recovery prior to the operation deemed to be so problematical, that it was decided to trephine. A button of bone was therefore removed with a one-inch trephine. The dura mater beneath was found to be inflamed, and adherent quite strongly to the inner surface of the bone. No evidence of fracture of the internal table was discoverable. The wound was then dressed with all antiseptic precautions, and the patient put to bed. Within twenty minutes after coming out from the influence of the anæsthetic, he was a changed man. He was free from pain, absolutely so. The twitching, which just before being taken into the amphitheatre was constant, had almost entirely disappeared, now being limited to the face *only*. To make a long story short, it is only necessary to state that the improvement thus begun continued until the patient's discharge from the hospital an apparently well man. On the second day after the operation he got out of his bed without permission and walked to the water-closet, a thing of which he was incapable before. He had but one rise of temperature, and that on the day succeeding the operation, and which we attributed to the visit of his wife. It might also be said that for a few days before the operation the man's temperature rose to 102; this fever was not explainable, except on the supposition of a meningitis being present.

This patient has been seen several times since his discharge from the hospital. He is a well man. What cured him? We do not know. We cannot say whether it was the dissection of the cicatrix from the skull or the opening of the cranial cavity, or both. Most would be inclined to say, at first thought, that the whole trouble was due to the cicatrix. If such is the fact, the above case is one of the most remarkable in the annals of medicine. It is a remarkable one in any event, but it would be more so if dependent entirely upon the cicatrix.

A very interesting observation concerning this case has been made since the man's recovery. We find that all events that trans-

pired during his illness are now a complete blank to him. While at home, and before he became confined to his bed, he had occupied his time in making ornamental articles. But on his recovery he remembered nothing concerning them.

I was therefore led to look up the bibliography of the subject of sensitive cicatrices and their effects. I knew of none in the last eight or nine years. The *Catalogue of the Library of the Surgeon-General's Office of the United States Army* gave reference to but two papers bearing on this subject. One of these was the report of a case of vaso-motor disturbance (flushing of the face with pain) starting from a sensitive cicatrix about the mouth, the result of a bite from a dog, and cured by counter-irritation and sedative medication by Mr. H. H. Clutton.\* The other article was very elaborate in character, and presented an extensive review of the subject. This paper was entitled "Neuralgia and Other Neuroses arising from Cicatrices of the Scalp, and their Surgical Treatment," by Frederick D. Lente, M.D.,† of Cold Springs, N. Y. In recent literature instances of cases bearing on the subject are reported by Mills‡ and White.§ This scarcity in reports of cases of nervous disease, and especially epilepsy, cured by excision of cicatrices, is all the more surprising in view of the very commonly accepted idea that such cases are of frequent occurrence. A recent writer (Schneider, in the *Berliner Med. Wochenschr.*, No. 43, 1889) says that we all have heard of such instances. Yet when one makes inquiries he fails to find hardly a single case as having been cured by such an operation.

Lente's paper deals largely with the effects of cicatrices in the scalp in their relation to neuralgia. The evidence he brings forward gives strong support to the occasional etiological relation between the two conditions. These cases reported are all convincing. Of his cases of amaurosis arising from the same cause, not as much can be said; all of them occurred in pre-ophthalmoscopic days, and therefore at a time when observations must have been faulty indeed.

In the cases of epilepsy reported by him as having been cured by operation, the same criticism can be applied as I have already made concerning the case I have above reported: The excision of the cicatrix was followed by a trephining, generally performed for the purpose of relieving pressure due to a possible depressed fracture of the

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\* *St. Thomas's Hospital Reports*, 1879.

† *Transactions of the American Neurological Association*, 1875, page 141.

‡ *Brain*, October, 1889.

§ *University Medical Journal*, February, 1890.



inner table of the skull. The most interesting case reported by Lente is that of an officer who received a gunshot wound of the scalp in the parietal region, the bullet ploughing away a portion of that bone. In consequence of this wound an epilepsy, with hemiplegia, was developed. After existing some time, the entire trouble was radically cured by excision of the cicatrix and trephining, no fracture, however, being discoverable. This was in 1865—certainly an old confirmation of the doctrines of cerebral localization of the present day. Lente speaks very strongly concerning the paucity of literature relating to the subject of epilepsy and cicatrices, and of all surgical authorities quotes only two as having had any experience with the subject, namely, the elder Gross and Willard Parker.

A case bearing great similarity to the one here reported is that of Mills, to which that author makes reference in his valuable brochure on *Cerebral Localization in its Practical Relations* :

“The patient had been subject to convulsions which seemed to date back to an injury of the head. He had a scar in, and apparently a depression of, the skull over the frontal region. Pressure on this scar brought on a unilateral, largely tetanic convulsion on the same side as the scar. A flap, including the scar, was lifted, and trephining was performed, but nothing abnormal was found in the inner table or the dura. The scar was excised.”

In the above case it will be seen that the same measures were employed as in our own. The main point of distinction between the two cases is, that in ours there was a marked meningeal inflammation, and the diploe of the skull was abnormally vascular. Mills reports another case in which excision of the cicatrix only, cured :

“The patient had convulsions, sometimes on one side and sometimes on both, and these could be brought on by pressure on a scar left by an old sabre cut. The cicatrix was cut out, and the patient recovered.”

White's case is extremely interesting. The extreme youth of the patient (three years) makes it more than probable that such an irritating cause (a cicatrix of the scalp) might very readily give rise to the symptoms reported. The indefinite character of the nervous symptoms, a condition which I have long held to be a distinguishing feature of reflex nervous manifestations, speaks strongly in favor of that view :

“Following the injury there was a marked change in the mental

and nervous condition of the child. He made no further effort at speech, became perverse and irritable in temper, and was subject to what the parents termed frequent nervous spells. These spells were characterized by twitchings, which were, at times, so great and so violent as to amount almost to convulsions. The scar lay directly on the sagittal suture, and was a half-inch in length, and about an inch and a half anterior to the vertex. The scar only was removed, trephining being left for a future operation, in case the excision of the cicatrix failed to cure. Six weeks after the operation the patient had had but one convulsive attack."

Cases bearing some similarity to the one under consideration are also reported by Dr. W. B. Fletcher, of Indianapolis, Ind., under the title "The Influence of the Dura Mater in Causing Pain, Reflex and other Phenomena, when Injured or Diseased."\* The first one was that of a patient with suicidal and homicidal impulses, who suffered great pain in the head. During the war he was cut along the centre of the parietal bone by an exploding shell, ploughing a groove into the bone. Into this groove the wound had healed into a firm dense adherent cicatrix. A triangular flap over the old injury was raised with the intention of trephining, but no fracture being found, nothing was done. Marked improvement, but not cure followed. The second case was one of injury to the scalp over the right parietal bone by an exploding boiler. Two years after the injury the patient had severe pain on the right side of the head, also severe epileptic convulsions, paralysis of the right side of the face, and nearly constant twitching of the right side of the face, neck, arm and hand. This patient was trephined. Thickened and adherent dura mater was found, which was broken up with difficulty, the manipulations of that membrane exciting muscular contractions. This patient made a complete recovery.

From the above remarks it will be seen that I have by no means arrived at a definite conclusion regarding what cured our patient. I believe that the trephining had something to do with it. I believe that the mere opening of the cranial cavity will, in some instances, exert curative influences, just as a similar operation performed on the abdomen will cure certain intra-abdominal lesions.

CASE IV.—*Jacksonian Epilepsy with Hemiplegia of Ten Years' Standing; Excision of Horsley's Wrist Centre; Improvement of Patient up to the Time of Writing.*—Charles W., æt. 16 years, was sent to my service at the Hahnemann College Dispensary by Dr. E. D.

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\* *Journal of the American Medical Association*, August 13, 1887.

Buckman. At the age of six years he was in perfect health. One Sunday morning, while being dressed by his sister, his left arm and hand became powerless, and within a few minutes the face and leg on the same side became similarly involved. The hemiplegia became complete, so that he was entirely unable to move. In the course of five or six weeks he was up and about, though the hemiplegia never entirely disappeared. No cause could be assigned by his mother for this attack, until she was told that two days before it occurred he fell, striking his head against a curbstone. No scar, or even abrasion, came from that accident. About one year after the hemiplegic attack he was seized with convulsions, of the Jacksonian type. These convulsive attacks consisted of a sudden flexion at the wrist, followed by a bringing of the arm somewhat forward. At the same time, the well hand would make an effort, by grasping the one in convulsion, to restrain the movements. During these attacks he did not lose consciousness. Sometimes the seizures would not be limited to the arm, but would spread to the leg, causing, so it was said, flexion at the knee-joint. Occasionally, he would have what were called his severe convulsions, in which the movements, while starting locally, would soon become universal. In these latter he lost consciousness. The minor attacks were of daily occurrence. The major ones recurred at long intervals only.

*Status Præsens.*—The patient is poorly developed for one of his years. The left leg and arm are both atrophied. The left leg is five-eighths of an inch shorter than the right, and the circumference of the thigh at its middle is one and a half in. less than its fellow. The left arm is held close to the body with the elbow and wrist both rigidly flexed, the rigidity being decidedly greater at the latter joint. A wrist clonus is readily attainable. The rigidity passes entirely away during sleep. The thumb is held rigidly in the palm of the hand. His gait is characteristic of old hemiplegias. Both patellar tendon reflexes are markedly exaggerated, and, at times, a patellar clonus is obtainable; ankle clonus also present. The cutaneous reflexes, though obtainable on both sides, are more marked on the right. His pupils react normally; the fundus oculi is normal. His mental development is poor; his memory, in particular, being bad. Temperature record, taken during his stay in the hospital, shows that it has ranged from slightly above normal to 100° F.

While the existence of a gross pathological lesion, together with its location, was plain in this case, the nature of that lesion was not so clear. Abscess and tumor were out of the question. The difficulty at the time of the hemiplegic attack was undoubtedly a hæmorrhage over the motor area of the cortex, exerting its first pressure on the cortical area centres, and spreading both upwards and downwards to the leg and face centres respectively. The rôle played by the supposed injury was not by any means clear. If there was

a depressed fracture of the inner table, and it had given rise to the hæmorrhage, the symptoms would have appeared much earlier; in fact, it is inconceivable that a traumatic sub-dural hæmorrhage could increase so slowly for two days as to then only begin to give rise to symptoms, and then, within a few minutes' time, spread from the middle of the Rolandic area to both upper and lower extremities of the same. But, what condition was present ten years after the primary lesion?

The indications were, however, clear. The boy was dependent for support on his mother. He was useless as a member of society; his life was in constant danger. An exploratory trephining was decided upon. Whether or not the cortical area for the wrist should be excised was left an open question to be decided by our discoveries made when the parts were exposed. Accordingly, on March 1st, Dr. C. M. Thomas brought the case before the class at his surgical clinic. The Rolandic area was carefully mapped out as in Case I., and a button of bone removed from the lower portion of the middle third of the fissure of Rolando by means of an inch-and-a-half trephine. On making an incision into the dura mater the convolutions came into view, though they were very much obscured by an œdematous infiltration of the pia mater. Examination with the finger now disclosed the fact that the anterior, or rather the pre-Rolandic, convolution was atrophied; besides this, and the thickening and œdema of the pia, no lesion was perceptible. The faradic battery was now called into play for the purpose of locating the wrist area.

FIG. 3.



Keen's Cerebral Electrode.

Keen's electrode was used for this purpose. On first applying the same to the cortex the weakest current possible was employed. This was gradually increased in strength until some effect was produced. The first spot selected for the experiment proved to be the one for which we were searching. As soon as a moderately strong current was obtained (about as strong as would excite contraction of the deltoid or biceps muscle when applied locally), flexion of the wrist took place; the electrode was immediately removed, but the boy passed through the remaining movements of one of his mild attacks. At the same time, he gave some evidence of not being fully under the

influence of the anæsthetic; further manipulation was stopped until he was fully etherized. Then the electrode was applied to the same spot once more, but with the same result. It was then placed upon other neighboring convolutions, but with negative results. Then, a third time, was it applied to the supposed wrist area, only to confirm the first observation. Dr. Thomas then excised this area, which was about three-eighths of an inch square, to a depth of one-half inch.

Up to the time of excising the cortex, irrigation was with distilled water only. This was done because Keen and Roswell Park claim that the faradic irritability of the cortex of the brain is destroyed by antiseptic solutions, as carbolic acid and mercuric chloride. It is worthy of mention, in this connection, that Lloyd and Deaver in their case reported in the *American Journal of Medical Sciences* for November, 1888, not only used mercuric chloride solution for irrigation, but when they came to locate the area for which they sought, they wrapped the points of the electrode in sublimated cotton and saturated the same in a solution of mercuric chloride, 1:1000.

The boy came out from the influences of the anæsthetic without difficulty. His progress since the time of operation to the present has been uneventful. On March 10th he was sent home; he has had no attacks of any kind; his mental condition has improved greatly. What the ultimate result will be must at the present time remain problematical. Of course, the movements presided over by the excised cortical area will be forever lost; but the left arm was useless prior to the operation, so that the patient cannot be considered any the worse off for the operation, for this reason. The propriety of the procedure adopted in this case has been attested by Horsley, Keen and others.

**CASE V.**—*Traumatism of the Head, followed by Attacks of Mental Aberration with Aphasia; Trephining over the Anterior Extremity of the Fissure of Sylvius; Death; Autopsy.*—Jesse K., æt. 31 years, conductor on freight train, was brought to the Hahnemann Hospital by Dr. Walley, of Mifflintown, Pa., on February 13, 1890. I saw the patient with Dr. C. M. Thomas, in whose charge he was placed. The following history was elicited: On October 2, 1888, he was struck on the left side and back of the head, knocked down and picked up in an insensible condition. Blood flowed from the nose and left ear; the left ear was cut externally; aside from the latter, the head bore no external manifestations of injury. His unconsciousness lasted three hours. When consciousness returned, the patient seemed to be entirely rational. He complained, however, of severe pain all through the head, grasping it (especially the left side)

with both hands. This pain lasted from 4 P.M. to 9 P.M., when it disappeared spontaneously. He then went to sleep and rested well throughout the entire night. Upon awakening he did not complain of much pain, and got up and shaved himself. He remained in this natural condition until about the middle of October. A change was then noticed in his speech; it became wandering and incoherent; he could articulate perfectly, but his thoughts were disconnected. A few days later he complained of coldness in his hands and feet, and then came absolute inability to articulate. This attack disappeared, leaving him with a disconnected manner of talking. In two weeks the same kind of an attack was repeated, and lasted one hour; before the attack had disappeared, he could not speak at all, only mutter and make sounds. The attacks above described were repeated at intervals of two weeks until December, 1888, when they occurred every other day. In January, 1889, none occurred. During this month he could speak clearly, but the pain in the head continued. At this time an eruption appeared in the beard upon the left side of the face. In the middle of February the "attacks" returned with greater severity than ever; they lasted longer, were accompanied by general tremor, severe pain, worse on the right side, and loss of power, gradually increasing until both sides of the body were affected; and then unconsciousness appeared. Between these attacks he could articulate with difficulty. When consciousness would return he would say, "Now I am better." He would then complain only of pain, placing his hand on the left side of the forehead mostly. His condition varied during March, April and May, but no new symptoms appeared.

During June he would awaken from sleep and scream out "I am going down." He would also jump up suddenly when in bed and cry that the ceiling was falling down upon him.

In August the abdomen became markedly distended; this lasted one day and was relieved by purgation. In December, 1889, Dr. Walley was called in to see the patient, who was constipated at that time. The doctor also obtained a history of incontinence of feces and urine at times; also, that during last summer and fall, he had lost all control of all extremities. For the past three or four months his condition has been apparently the same as at present. He eats well, with no difficulty whatever in swallowing either liquids or solids. He apparently is unable to recognize his surroundings. He cannot tell when urine or feces are voided. Sleep is variable; sometimes it is good and at others it is restless. He sleeps but little during the day. When excited he will "grit his teeth" and indulge in profanity. Otherwise than the few profane words uttered, he does not articulate at all. The sight of the left eye has been said to have been lost since the accident. His pupils react normally. An ophthalmoscopic examination was not satisfactory, though it was thought that the disk was markedly paler than normal. The patient makes more or less constant efforts to speak, which end in muttering and unintelligible sounds. He makes efforts to grasp and shake hands

with those who approach him. He is unable to walk without assistance. During the patient's stay in the hospital his appetite was good. Much of the history was confirmed so far as it related to his present condition. When his wife called upon him he recognized her at once, and caressed her, but he never spoke. He frequently placed his hand upon the left side of the head in such a way as to make it impossible to tell whether the discomfort which excited the act was in the forehead or in the back part of the head. Numerous attempts were made to test the surface temperatures of the scalp. The areas or stations selected for this purpose were almost invariably a degree higher on the left side than they were on the right; but the relative temperatures of the stations on the same side were extremely variable. At one time the occipital station gave the highest register, while at other times the frontal was the highest. The study of the surface temperatures of the head as a localizing symptom was therefore abandoned. During the last three days of February, 1890, the patient failed not a little. His appetite lessened somewhat. He also had a slightly increased general temperature.

The exact nature of the above case was a puzzle from the start. The initial appearance of the symptoms two weeks after the accident pointed to traumatism as a cause. But the localizing symptoms were by no means as clear cut as they might have been. Owing, however, to the fact that the initial symptoms in the case were mental impairment, and that the disorder in speech was secondary to the same, I came to the conclusion that the lesion, whatever it was, started in the frontal lobe, on the left side, just anterior to the fissure of Sylvius. This view seemed to find confirmation furthermore in the point of original injury which was on the left side of the front of the head. There were no symptoms pointing to other areas of the brain as possible seats of disease. The inability to control the movements of the limbs was entirely unexplainable by the above diagnosis, however. The disorder in speech seemed to be an aphasia, and nothing else. There was no paralysis of cranial nerves; no sign of lesion of the bulb; and the man could utter a few words of emotional nature, as those used by him in the indulgence of profanity. The most likely lesion that would follow an injury to the head is abscess of the brain. I therefore advised an exploratory trephining, the opening to be made right over the anterior end of the fissure of Sylvius, and in front of the ascending branch of that fissure. Thus the portion of the brain immediately over the roof of the orbit, and at the junction of the anterior and middle fossæ of the skull, was exposed. An abscess starting in this neighborhood might very readily excite mental disorder at first, and then, as it increased

in size, its pressure backwards would cause interference with the functions of the speech area.

The trephining was performed. The dura was incised by a crucial incision, and the brain bulged markedly. There was, as in the preceding case, an effusion beneath the pia mater, obscuring the convolutions. On incising the latter membrane there appeared a copious flow of serum. To discover the presence of any abscess in this neighborhood a grooved director was now passed in several directions to the depth of an inch and a quarter, but nothing was found. The serous flow continued throughout this procedure; in fact, the fluid running down the convolutions, and coming in contact with the grooved director poured off that instrument in a manner almost to indicate that it came from the puncture of the brain tissue itself. The patient was then dressed and put to bed.

Following the operation there was no improvement in his mental condition, nor indeed was there any aggravation. He was as oblivious of his surroundings as before; and the only words uttered were his profane ejaculations. At seven o'clock on the morning following the operation he was seized with convulsions, said convulsions being limited to the right side of the face and the right arm; the leg remaining perfectly quiet. The head and eyes deviated to the right. He was apparently unconscious. The convulsions continued without alteration until death took place, fifty-one hours after the operation. A post-mortem examination was held on the evening of the day of his death by Dr. Carl Vischer, Drs. C. M. Thomas, John E. James, R. B. Weaver, H. L. Northrup, J. M. Caley, and myself being present. The only abnormality discoverable was an universal œdema of the pia mater. The effusion was in no one place any greater than in another, though the thickening of that membrane was decidedly more marked over the left half of the cerebrum. The brain substance was apparently normal. The membranes were nowhere adherent. The ventricles were enormously dilated and filled with the same serous fluid as was found on the convexity of the brain. At the roof of the fissure of Sylvius was found a very slight hæmorrhage, of almost paper-like thickness, and extending through the entire length.

It will thus be seen that I was mistaken regarding the existence of a local lesion. It will furthermore be noted that the autopsy fully explained all the symptoms present in the case, from the mental impairment and aphasia to the convulsions and the inability to direct the movements of the extremities. The most surprising feature of the case is that such a lesion should have resulted from injury. There was no inflammation of the dura mater. Inflammation of



the pia-arachnoid with effusion, so far as my reading goes, is hardly mentioned as a sequence of traumatism.

The localized character of the symptoms is in perfect keeping with the symptomatology of chronic meningitis; in fact, it might be said that there is nothing that chronic meningitis cannot do in the way of producing symptoms. It would seem to almost vie with hysteria in this respect.

It seems to me, even with the results of the operation known, that the entire procedure was justifiable. The only thing not done, that might have been done with some prospect of benefit, was tapping of the ventricles. But we had no evidence that a condition requiring such a procedure existed. The man was in a condition of a "living death" prior to the operation, and was rapidly failing. Had it been otherwise, the operation would not have been attempted.

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### LYCOPODIUM CLAVATUM.

BY AUG. KORNDORFER, M.D., PHILADELPHIA.

THE pathogenesis of this remedy, comprising, as it does, more than thirty-one hundred symptoms, offers to the student of materia medica a most formidable task, a fact which but too frequently results in neglect of this oft indicated and invaluable antipsoric.

Hahnemann, in his introductory remarks to lycopodium, *Chronic Diseases*, vol. iv., says that, "although the old school had, until his day, taught that it possessed scarcely any medicinal virtue, nevertheless, if prepared according to the homœopathic method of trituration and potentization, it proves itself to be endowed with most wonderful curative qualities in its thirty different grades of dynamization. In these preparations, lycopodium becomes one of our most indispensable antipsoric remedies."

In critically reviewing its lengthy pathogenesis for the purpose of forming a condensed, yet comprehensive, synopsis of its specific effects, we are impressed with the very marked condition of weakness, which involves both mind and body of the lycopodium patient.

The weak memory of the aged may, in many cases, be ameliorated by its use.

Weakness of digestion, with great accumulation of gas in the

stomach and intestines, is very prominent ; the flatus is odorless, and there is but little unpleasant taste in the mouth, a fact which serves to differentiate it from arsen., carbo veg., and others.

Symptoms of torpid action of the liver, with hepatic congestion, hæmorrhoidal affections, constipation and oftentimes entire loss of appetite, are prominent.

A peculiar and frequently-observed symptom of the lycopodium patient is an inordinate hunger which, after even a few mouthfuls of food, speedily gives place to a sense of repletion, so that he cannot eat any more.

Reflex heart-symptoms occurring during digestion, are by no means uncommon.

Looking further, we find oversensitiveness of sight, hearing and smell, though not necessarily combined in any one given case.

Note the fact, also, that the orifices of the body, *i.e.*, eyelids, ears, nostrils, lips, prepuce, vulva and anus are apt to be the seat of characteristic symptoms.

The most prominent painful sensations are either burning, cutting, or tearing. The most prominent aggravations occur between 4 and 8 P.M.

Women in advanced life, as well as persons of keen intellect but of feeble muscular development, predisposed to affections of the lungs and liver, often find in lycopodium the similitum to their diseased states.

Especially is this true, if there is also a marked disposition to catch cold from slight exposure.

Such a brief sketch of its sphere of action, though giving but a faint idea of its individuality, serves to fix in the mind the general character of many of the cases to which lycopodium stands in homœopathic relationship.

With this as an introduction, and bearing in mind Hahnemann's instruction, *Organon*, § 153, that "we ought to be particularly, and almost exclusively, attentive to the symptoms that are striking, singular, extraordinary and peculiar (characteristic)," let us cull from its voluminous provings such symptoms as give it individuality among the remedies of the materia medica.

As before stated, mental, as well as bodily, weakness is prominent ; thus, we find : Vanishing of thoughts ; confusion of thoughts ; inability to find correct words to express his thoughts ; uses wrong words for correct ideas ; memory becomes weak, especially during advancing age.

In mood, the lycop. patient is sensitive and inclined to be tearful. This must be distinguished from a similar symptom of such remedies as pulsat., ignat., coccul., etc.

Lycopod., though mild, is more imperious and less variable than pulsat. or ignat. It is, also, markedly distrustful and fault-finding.

In mildness, it compares with coccul., calad., crocus, cupr. m., ignat., pulsat., silic.

In distrust, with anacard., baryt., bellad., caust., cicut., droser., helleb., hyosc., pulsat., sulph. ac.

In peevishness, with anacard., aurum, calc. c., caust., cham., hepar, ignat., ipec., merc. v., natr. c., nitr. ac., phos., phos. ac., platin., pulsat., sarsap., silic., staph., sulph., viol. tr.

In haughtiness, with platin., stram., veratr.

It has much less variableness than either aurum, ignat., platin., pulsat. or sulph. ac.

Covetousness is marked in lycopod., as well as in arsen., bryon. or pulsat.

Despondency is observed to a marked degree, and melancholy has been cured by lycopod. Doubts about her salvation may occur, especially before the menses. Satiety of life may be an accompaniment in such cases.

Vertigo, when drinking and when stooping.

The headaches are variously described as stupefying, stitching, pressing or tearing in character; they occur mostly on the right side and are worse between 4 and 8 P.M.

The tearing pain begins in the forehead, or right side of the head, and extends down to the neck, involving the face, eyes and teeth. Sanguinaria has headache beginning in the occiput, and spreading to right temple and eye. Silic. has shooting pains from the nape of the neck to the vertex, relieved by wrapping up warmly. Spigelia has pain which begins in the occiput and spreads over the left side, becoming a violent pulsation in the left temple and over the left eye, in periodical attacks. Rhus rad. has severe aching, beginning in the occiput or sub-occipital region, and spreading through to the forehead, jarring or jolting as when riding causes severe aggravation. Juglans cath. (preparation of the bark from young branches) has violent sub-occipital headache; also, has violent pains in the region of the axis vertebra. A single dose of the 30th potency is usually sufficient. I have seen a second dose cause severe aggravation, thus confirming an observation made by Dr. J. Jeanes, many years ago.

Lycopod. has an eruption beginning on the back of the head, spreading to the ears and face; it is thick and crusty, oozing a fetid moisture, and bleeding easily. Scratching, as well as warmth, aggravate.

Pityriasis in spots on the scalp. Hair falls off in spots. Loss of hair after typhoid fever.

Among the eye-symptoms we must mention night-blindness coming on early in the evening, with black spots before the eyes; also, perpendicular half-sight; sees only the left half of an object distinctly. In this condition, compare lithium carb., mur. ac., natr. m. In horizontal half-sight, upper half dark, think of aurum.

Cataract has been relieved by lycop. Think also of magn. m., sulph., amm. mur., silic., and graph., as having been eminently serviceable in the treatment of this condition.

Acute as well as the chronic forms of inflammation of the eyes and lids, with lachrymation during the day and agglutination of the lids at night, accompanied by photophobia, may call for lycop. The conjunctiva is very red, looking like raw flesh. Stytes near the inner canthus. Itching in the canthi, especially the inner.

The hearing is oversensitive; music and sounds affect the ears painfully. Roaring, humming and whizzing in the ears. Purulent otorrhœa; polypus of the ear. The closing of the nostrils by purulent discharge, at night, reminds us of the agglutination of the eyelids.

Obstruction at the root of the nose; must breathe through the mouth; the breath being interrupted, the child starts and screams. Think also of acon., nux vom., puls., and sambuc.

The coryza of lycop. is acrid, excoriating the lips. When such a discharge occurs during scarlatina, compare also arsen., arum. tr. and nitr. ac.

The mouth bears evidence of the depraved state of the digestive organs and the consequent faulty nutrition in the easily bleeding gums; offensive smell from the mouth, especially in the morning on awaking; vesicles on the tip of the tongue, which feels scalded or raw; and the ulcers in and under the tongue. The mouth is dry. The taste may be bitter, though frequently there is no unpleasant taste.

Swelling of the lower lip is often observed. Lachesis has swelling of the lower lip, and bell., calc. c. and sulph. of the upper lip.

Teeth painful to the touch (sulph., as if too long). Yellow color of the teeth. Toothache, with swelling of the cheek, ameliorated by

the heat of the bed, compare bryon. and nux vom.; and from warm applications, compare rhus tox., staphis, arsen., ant. cr., etc.

Mercur. is worse from heat of the bed. Cham., though occasionally better from heat, has more prominently pain recommencing on entering a warm room and is worse from drinking anything warm.

Inflammatory enlargement of glandular organs often finds its similitum in lycopod. We find it curative in acute or chronic enlargement of the tonsils. Ulceration of the tonsils, first right, then left. In this it is similar to merc. prot. iod., from which it may readily be distinguished by the thick yellow coating of the tongue of the m. p. i. (Lachesis and the merc. bin. iod. have first left, then right.)

The ulcers in the throat of the lycop. are accompanied by fetid odor and often by purulent discharge from the nose. Tickling sensation in the ears is a frequent accompaniment in throat affections. Hawking up of bloody mucus is common.

While lycop. is usually characterized by the symptoms, small quantities of food satiate, the abdomen becoming bloated from the least food; we also find attacks of ravenous hunger causing headache if not satisfied; cactus grand. also has headache when getting hungry.

Though frequently indicated in gastric derangements, there seldom is vomiting. Nausea often exists in the morning. Riding in a carriage causes nausea. In such cases compare arsen., borax, coccul., hepar, ignat., nux mos., petrol., sepia, silic., sulph.

Nausea, *after* riding in a carriage, requires nitr. ac.

(Seasickness usually yields to arsen. 30 or coccul. 6, as I have been able to verify in many cases.)

Characteristic of lycop. is painful swelling, as well as sensitiveness of the pit of the stomach to tight-lacing or touch. Compare lachesis. Cancer of the stomach has been relieved by lycop.

A symptom pointing to lycop. in widely different forms of disease is continuous rumbling about the left flexure of the colon; occasionally it may also be in the right.

Sulph. has a similar rumbling in the region of the sigmoid flexure.

Chronic affections of the liver following fright often call for lycop. Constipation is common, the stools are hard, and there is an ineffectual desire for an evacuation. We also find excessive contraction of the sphincter ani, pain continuing hours after a passage; compare plumb.

Diarrhœa, stools green, slimy and odorless. The odorless discharge corresponds to the odorless flatus which is so characteristic of lycop. The obstructed portal circulation results in painful protruding hæmorrhoids, which are worse when sitting.

Hæmorrhage from the rectum even after a soft stool.

Itching eruption around the anus, painful to the touch. Sulph. has a similar eruption, which, however, is not so painful.

The most characteristic symptom of the urinary organs is the red sandy deposits in the urine. There may be great delay in passing the urine, with severe pain in the region of the kidneys.

Another and quite contrary symptom found in nervous states calling for lycop. is frequent desire to urinate, with discharge of large quantities of pale urine.

Hæmorrhage from the bladder, painless.

Stitches in the neck of the bladder and in the anus at the same time. This symptom may accompany hæmorrhoids. Renal colic, especially left side. Raue recommends it for the right side after nux vom.

The lycopod. weakness is marked in the sexual organs by impotence; the penis is small, cold and relaxed. Excessive and exhausting pollutions may occur. In this condition think also of kobalt., nux vom., phos. ac. and cinch.

The menses are too profuse and last too long; or may be suppressed from fright.

Dysmenorrhœa with the characteristic abdominal distension and accompanied by pain in the temples, as if screwed together.

The vaginal mucous membrane may be dry, or we may have a milky-looking leucorrhœa, often corrosive, and sometimes bloody.

Flatus passes from the vagina. This symptom has also been observed in brom., nux mos., phos. ac. and sanguin.

Hard, burning nodosities in the mammæ may call for lycop., though carbo an., as well as arsen., should be carefully studied.

Soreness and bleeding of the nipples during lactation has been cured by lycop., though the constitutional rather than the local condition leads to the choice.

Stinging in the nipples.

The chest affections of children requiring this remedy are characterized by loss of vitality, the child becoming very quiet; shortness of breath, especially during sleep; child cannot yawn, and cries because the yawning is interrupted. Bronchial and pulmonary affections quite frequently call for this remedy. The cough of lycop.

is usually worse towards evening (between 4 and 8 P.M.), and is aggravated by exertion and on alternate days; also from stooping; from lying, especially on the right side; from exposure to the wind, and in the warm room. Expectoration, especially during the day, copious, purulent, gray, salty; or, bloody, rust colored. The morning cough is accompanied by green expectoration; compare *stann.*, *sepia*, *puls.* and *paris.* The stitches in the chest remind one also of *bryon.*, *kal. c.* and *squilla*.

In pneumonia, during the stage of hepatization, *lycop.* is frequently indicated. The circumscribed redness of the cheeks, the dryness and redness of the lips and tongue, the aversion to covering and the irritability of temper on awaking, together with the rusty sputum and fan-like motion of the *alæ nasi*, form reliable guides.

Threatened paralysis of the lungs is another form in which the general adynamic state so characteristic of this remedy is manifested.

Palpitation of the heart, worse during digestion; also palpitation mostly toward or during the evening; it may be so violent that the patient must stand still, yet standing fatigues.

Rheumatic pains and tension in the right shoulder-joint. Stiffness and pain in the back and small of the back, and soreness and stiffness of the neck. Weakness of the arms. The fingers "go to sleep" easily. Inflammatory redness and swelling of the finger-joints. Burning in the palms, similar to *sulph.*

Nightly tearing pains in the legs. Swelling and stiffness of the knee. Swelling of the whole leg.

*Lycop.* has proved curative in phlegmasia alba when the saphenous vein is much swollen and tender.

Pain in the soles when walking; the heels are especially painful. Cold sweaty feet, think also of *calc. c.* Feet become sore from the sweat, think also of *silic.* Gouty stitches in the right great toe.

Sleep disturbed by startings, reminds us especially of *bellad.*, *coff.*, *sulph.*, *caust.*, *silic.*, *lachesis* and *lycop.* Children fear to be alone when falling asleep. Sleepiness in the daytime, but cannot go to sleep at night; the mind is too active; compare *bryon.*, *calc. c.*, *cinch.*, *coccul.* Unable to find ease in any position, also *acon.*, *arsen.*, *rhus*.

The chill, as well as the fever, is marked by the 4 to 8 P.M. periodicity. The chilliness is often of one (left) side only. Flushes of heat, mostly toward evening, with frequent drinking of but small quantities at a time; compare *arsen.*, *carbo veg.*, *cinch.*, *corn. flor.*, *eup. perf.*, *hyosc.*, *rhus tox.*, *squilla*. As might be expected from the general weakness manifested, we find profuse perspiration during

the day, excited by the least exertion. We also have night and morning sweats, often with coldness of the face.

In accordance with old experience, we find *lycop.* eminently useful in easily bleeding excoriations, especially those occurring during infancy and early childhood.

The most characteristic of the skin symptoms are: Humid suppurating eruptions, full of deep rhagades, and covered with thick crusts, itching violently. Bluish looking blood-boils, which do not mature. Chronic forms of urticaria.

In conclusion it may be well to remark that *lycop.*, though of the highest importance as an antipsoric, is but rarely indicated at the beginning of treatment of chronic diseases. It, however, follows other antipsorics, such as *calc. c.* or *lachesis*, with marked effect, and, in fact, is often indispensable to a cure.

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#### AN ACCIDENTAL PROVING OF ANACARDIUM.

BY C. H. THOMAS, M.D., CAMBRIDGE, MASS.

IN pursuing our studies of the *Materia Medica*, all have no doubt experienced the cerebral inadequacy to thoroughly grasp and store away many of the pathogenetic effects of the drug under scrutiny. Such an experience fell to me recently, the facts and results being briefly as follows:

A student presented himself with symptoms of inability to concentrate his mind on his studies; lack of confidence in himself to undertake his coming examinations; feeling of general lassitude, and a most persistent frontal headache. *Anacardium orientale* appeared to be the *similimum* in his case, and results verified the selection, as he "took a brace," as he expressed it, and went through the "swim."

In preparing the medicine, I accidentally let four to six drops of the 3x dilution fall upon the back of my left hand, and, unconcernedly wiped it off with the palm of my right. This occurred Thursday, January 2d, in the evening. Friday afternoon and evening there was a feeling of warmth, attended by slight itching and burning, which I attributed to a case of erysipelas I was then attending. Saturday morning found the back of the left hand much swollen, very red, itching and burning intensely, and, in addition thereto, the lobes of the ears presented the same condition. Sunday,



the symptoms were much aggravated; the right wrist and internal aspect of both legs from the knees to the groins participating in the general disturbance. The thought struck me very forcibly, could it be erysipelas or had I been exposed to some poisonous plant. Early Monday morning, I addressed my room-mate rather abruptly, inquiring, "What's that?" and was informed no remark had been directed to me. The succeeding week the eruption assumed a vesicular form, then became pustular and umbilicated, the pustules rupturing when lightly irritated, the exudation drying into a hard semi-transparent scale, the skin becoming exceedingly rough, cracked and bleeding.

*Anacardium* came to me as a possible source of this cutaneous irritation, and Hughes and Farrington were consulted and covered the whole case. *Juglans regia* being regarded as antidotal, it was tried with some success; during the most inflammatory stage, calendula and rose water relieved the itching somewhat, but to hot water the greatest relief was due. The eruption lasted for over three weeks, and then a very severe synovitis of the left knee was ushered in, which apis and hot applications greatly benefited. There was a continual feeling of contraction of the quadriceps extensor tendon, and much pain and discomfort when the limb was flexed, the act of extension creating a sensation as if the tendon passed over a raw and sore bursa. This at the present time (March 27th) has not entirely disappeared.

It is needless to add, I have placed a red label on *anacardium* marked "*Poison*," and will give it a wide berth in future.

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THE IODOFORM TREATMENT IN BURNS AND SCALDS.—Two indications prevail, to stop the pain and cati-sepsis; iodoform responds to both, and has the advantage, as Mosetig-Moorhof has shown, that the bandage may remain untouched for one or two weeks, which is a great comfort to the patient. Iodoform also hastens granulation. The blistered skin is removed, and the wound cleansed with antiseptic cotton moistened with a solution of  $\frac{1}{2}$  per cent. sodium chlor. On the wounded surface Scheff then applies several layers of dry iodoform gauze; over it a layer of gutta-percha paper, which prevents any adhesion of the cotton which might become stiff from the secreta, and the whole is held firmly by the usual bandage. The cotton can be changed whenever necessary, while the iodoform gauze remains untouched for one or two weeks. For the face he recommends an iodoform vaseline salve, 1 to 20, covered with a rubber-paper mask, which must be renewed daily. He never witnessed any poisoning, from this mild treatment.—*Monatshfte f. Dermatol*, 2, 1890.

## EDITORIAL.

### THE DISPENSARY ABUSE.

THE abuse of dispensaries is so apparent, so real, and so steadily increasing, that it is not to be wondered at that current medical literature is flooded, time and time again, with ably written protests which, unfortunately, have resulted in absolutely nothing towards eradicating the evil. As usual, this abuse falls heaviest where it can least be borne, on the young practitioner, while he is still struggling hardest with the bread-winning problem. It is admitted that dispensaries are necessary evils, under two conditions: First, where they will be a practical benefit to the real poor. A very few institutions will supply this demand, even in a city of a million inhabitants. A corporation furnishing to any one, but the needy poor, gratuitous advice and medicine, is a monopolistic organization for purely selfish purposes, and it is robbing the general profession of money that is justly due it. Such a dispensary cannot plead the excuse, "needed for clinical instruction." Secondly, a dispensary is now an imperative requirement of a college or teaching centre. Didactic teaching is fading away with the century, and will soon be a method of the past. Clinical instruction is such a great improvement on the old way, that the advance student demands it in unmistakable language, and all acknowledge the justice of his claim. To supply this call, colleges must have clinical material. While we endorse the motive actuating and maintaining college dispensaries, we hold that the method of conducting them is open to criticism and censure. Fully one-third of all applicants for dispensary relief can afford to pay for services rendered, and would pay a fair price, if it was demanded of them. What dispensary ever questioned applicants on their ability to pay, and excluded those whose means were sufficient? If there is such a one, we have yet to hear of it. Granting the possible necessity of accepting well-to-do patients to make good the supply of material for teaching purposes, what dispensary ever refused attendance to such patients, when the supply was sufficient to meet the demand? The rule with all dispensaries has been, and is, to accept all persons applying for treatment without questioning their ability to pay, whether the case be an instructive one or not. To reform this abuse, it will be necessary to have those

in authority make an earnest, positive effort to ascertain the financial standing of each applicant for relief, and to rigidly exclude all well-to-do patients who are not absolutely needed for clinical purposes; here, too, exception should only be given to rare cases with instructive value. With other institutions, having an out-door department for the gratuitous treatment of the sick, refusing to discriminate in favor of the real poor, it becomes the duty of the profession to educate the laity to the true situation, and to urge their friends to withdraw from such organizations their patronage and financial support. This, we believe, is the correct way to solve this vexed question, and not as the *Medical Record* has suggested, in a recent editorial: "If the young practitioner, or the old one either, for that matter, wants to correct this abuse, he must act, he must combine with his fellow-sufferers, and see what he can do for himself in the matter. Let him fight fire with fire. If it is allowable for a number of physicians to treat patients free during certain hours at a dispensary, why is it not equally permissible for the individual to do so? Let every physician who wishes to increase his *clientèle* and to make himself known in a legitimate way to a larger circle, have certain hours of certain days, during which he will treat gratuitously the deserving poor, and let him see to it that the fact becomes known in his neighborhood. It will not be long before he finds himself with plenty to do in these hours, and if he does his best for these free patients, he will soon find his waiting-room comfortably filled during his paying-hours." This scheme may not be "wild or revolutionary," and it may be an effectual cure for the evil, but what about new evils? It certainly means that the profession would degenerate into a conservator of pauperism. The individual members would, undoubtedly, grow lax in the careful discrimination between "well-to-do" and "deserving-poor" patients. Thus, the result would be a severe blow to professional dignity; such being the case, the suggestion cannot be too emphatically condemned.

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#### THE SIMULATION OF HYSTERIA BY DISSEMINATED SCLEROSIS.

THE frequency with which disseminated sclerosis is mistaken for hysteria has often excited our comment. It is not only among novices in the profession that such diagnostic errors occur, but among veteran diagnosticians as well. In fact, we might say that we have known

such mistakes to be made by men of world-wide reputation. It was with great interest, therefore, that we read the report of an address delivered before the London Neurological Society, by Dr. Thomas Buzzard, on the "Simulation of Hysteria by Organic Diseases of the Nervous System,"\* and in which this subject is handled in a most able and interesting manner.

The lecturer, after remarking on cases of atrophy of the iliopsoas group of muscles, Friedreich's ataxia, carcinomatous neuritis, as occasional sources of error, proceeded to the consideration of disseminated sclerosis, and its simulation of hysteria. Of all organic diseases of the nervous system, disseminated sclerosis, especially in its early stages, is the one which is most readily taken for hysteria. The causes of error Dr. Buzzard ascribes to the fact that both affections occur in young females at the age of puberty; that oftentimes a moral shock precedes the first symptoms; and the occasional association of disseminated sclerosis with true hysterical symptoms. The above sources of error are all well recognized by the profession generally. But, what is not well known, is the fact that many of the symptoms of disseminated sclerosis itself are such as are supposed to suggest a hysterical origin. "A sudden or gradual loss of power in a limb of an apparently healthy female, a localized numbness, or pins-and-needles sensation, and complaint of loss of sight in one eye, are symptoms familiar enough as expressions of functional trouble." They represent, also, modes in which disseminated sclerosis may make its first appearance. As in the case of hysteria, these symptoms may shortly disappear. Later, these same symptoms make their appearance elsewhere than in their original point of attack. The other eye becomes affected; the numbness and formication which at first appeared in the hand now invades the opposite hand or the foot. Then comes some stiffness of the legs, and the patient complains of weakness and inability to stand. These symptoms likewise disappear. Now this fleeting character of the symptoms, and their tendency to migrate from one part of the body to another, is usually believed to be a positive sign of hysteria. That this is an error is shown by the onset, sooner or later, of characteristics which point unerringly to a diagnosis of disseminated sclerosis. The loss of power, in disseminated sclerosis is rarely more than moderate, while in hysteria it is generally complete. The shifting of loss of power from one limb to another is usually significant of disseminated sclerosis, and not of

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\* *The Lancet*, February 8, 1890.

hysteria as commonly believed. The idea that this shifting of the paralysis is diagnostic of hysteria has arisen, in Dr. Buzzard's opinion, from the many mistakes in "diagnosing as hysteria cases of disseminated sclerosis, which have occurred before the latter disease had been differentiated." The author admits the proneness of the hysterical patient to changes of disorder, but the shifting of the symptoms which is met with in disseminated sclerosis he cannot help but regard as *sui generis*. As with paralysis, so with the loss of sight in hysteria; both symptoms are, in this disease, liable to be complete. In disseminated sclerosis, on the other hand, the trouble amounts only to an obscuration of vision.

Dr. Buzzard places a high diagnostic value on the tremor during intentional movement which occurs in disseminated sclerosis. In not one case in which he has observed this symptom has the future history of the case shown it to be of functional nature. The hysterical tremor that is most likely to be confounded with that above mentioned is one in which the finger touches the desired object without any hesitancy, but, when it has rested upon the object for two or three seconds, the arm becomes affected with somewhat rude tremors.

Localized atrophy of muscles, with loss of electrical reaction, often occurs during the course of disseminated sclerosis, but this local atrophy, like the paralysis, may shift from place to place.

We commend the lecture by Dr. Buzzard to the careful consideration of our readers. It has, no doubt, often happened with all of us that cases which, in the beginning, we regarded as either fictitious or else of a hysterical nature, have later proven to be true organic diseases. As our knowledge concerning the means of recognition of the latter class of ailments increases, hysterical cases of certain kinds become less and less frequently diagnosed. While making this statement we must not lose sight of the fact that the opposite error frequently obtains, and patients condemned as having incurable organic diseases are, later, proven to be sufferers from hysteria or some other functional disease.

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PHARISEE ALLOPATH, M.D.

AT a recent banquet, Dr. Pharisee Allopath, objected to being called anything but plain "M.D." As a regular physician means, or should mean, a person thoroughly versed in medicine in its

entirety, it, naturally, would be the height of impropriety to call a member of the so styled "regular" school of medicine an M.D., that is, in the sense meant by Pharisee. The old-school practitioners are responsible for medical sectarianism, and until they take steps to rid the profession of sects, by teaching homœopathy in their colleges, they will never escape being called allopaths. Let them purge themselves of presumption and arrogance. Let them be men. Let them treat the opinions of others with toleration. And, finally, let them handle homœopathy honestly, and there will soon be no sects in medicine.

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DR. L. B. HAWLEY.

DR. L. B. HAWLEY, of Phoenixville, died on March 20th, 1890. The Doctor graduated at the Homœopathic Medical College of Pennsylvania, in 1853, and located in Phoenixville in 1855. He was one of the organizers of the Homœopathic Medical Society of Chester and Delaware counties in 1858. In 1863, he moved to Kinderhook, N. Y. After a residence of a few years there, he returned to Phoenixville, where he remained in active practice until within a few weeks of his death.

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DR. R. F. KREBS.

DR. R. F. KREBS died at his home in Reading, Pa., on the evening of April 5, 1890. The deceased was born May 28, 1832, at Glatz, Prussia. He was graduated in medicine from the University of Prague, in Austria, in 1855. Soon thereafter he came to America, and located at Boston, Mass. In 1857, he removed to Hamburg, Pa. He continued there until 1884, when he removed to Reading. An autopsy, made by Drs. W. A. Haman and E. Z. Schucker, showed that the immediate cause of death was hæmorrhage into the left lateral ventricle.

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DR. C. S. ROBERTS.

JUST as we go to press we learn of the sad death of Dr. C. S. Roberts, of Rockland, Maine, by drowning on the evening of April 21, 1890. The doctor was a promising young man, one of the class graduated from the Hahnemann Medical College, of Philadelphia, on the evening of April 2. It was his intention to have settled shortly in Omaha, Nebraska.

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## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

**THE ESTIMATION OF URIC ACID.**—Of the methods in use for the estimation of uric acid some are too delicate and some are wanting in precision. M. Arthaud and Butte propose the following: It is based upon the property which uric acid possesses of forming with salts of copper a completely insoluble urate. At first, sulphocyanide of copper in solution with sodium hyposulphite was employed, but the following is the formula of the solution now used: Sulphate of copper, 1.484 grammes; sodium hyposulphite, 20 grammes; sodium and potassium tartrate, 40 grammes; distilled water, a sufficient quantity to make a litre of solution. The cupric salt in contact with the sodium hyposulphite is reduced, and the excess of hyposulphite helps to maintain the salt of copper in the cuprous stage; the part played by the soda tartrate consists in giving stability to the reagent and prevents the formation of sulphide of copper. Experiment has shown that 1.428 gramme of sulphate of copper is necessary to precipitate 1 gramme of uric acid. In order to estimate the uric acid in urine the phosphates are first precipitated by the use of sodium carbonate in excess. After filtration, 20 cubic centimetres of the urine are taken, into which the reagent is added drop by drop by means of a burette. A milkiness is at first produced, and then a white flocculent precipitate separates. When it is considered that the limit has been reached, a small quantity of the liquid is filtered, to which is added a drop of the reagent. If any opacity is produced, the precipitation of the uric acid is not complete. The process is stopped when the filtered liquid is not affected by the reagent. This method is considered by M. Arthaud and Butte to be a very accurate one.—*British Medical Journal*, March 1, 1890.

**EARLY SYMPTOMS OF LOCOMOTOR ATAXIA**—1. *Cerebral Symptoms.*—Fainting, vertigo, apoplectic attacks, with or without cardiac symptoms, epileptiform seizures. Fainting fits in nervous persons, or under the influence of external accidents, do not ordinarily attract the attention of the physician, but fainting fits from no assignable cause should at once arouse a suspicion of oncoming tabes. Severe attacks of vertigo, so severe, indeed, as to cause the patient to fall, especially when associated with impaired motility, should be regarded as suspicious. Apoplectic attacks, followed by total hemiplegia or aphasia, but passing off in a few hours or days, and epileptiform convulsions are early symptoms of tabes.

2. *Symptoms Referred to the Cranial Nerves.*—The amblyopia attacks the two eyes at different times and in different degrees, thus differing from the alcoholic amblyopia. Vision for distance is first to diminish, the field of vision becomes progressively narrower, and there is blindness for red and green. The atrophy runs a slow progressive course, thus differing from retro-bulbar neuritis and that of multiple sclerosis.

**Auditory nerve.**—Subjective noises, bilateral progressive hardness of hearing, Meniere's vertigo from peripheral degenerative neuritis or degenerative neuritis in the bulbar region.

**Paralysis of the external muscles of the eye;** double vision, abducens and oculomotor nerves mostly affected, Argyll-Robertson pupil.

**Trigeminus.**—Pains, partial anæsthesia, often in connection with paræsthesiæ, loss of teeth, all probably from an ascending degeneration in the sensory root of the trigeminus.

**Facial paralysis,** transitory in character. Disturbances in the vagus, spinal accessory and glossopharyngeal; laryngeal manifestations; fits of suffocation, with stridor and cyanosis rapidly passing off or becoming fatal; uni- or bilateral paralysis

of the vocal cords; difficulty of deglutition; angina pectoris; unilateral atrophy of the tongue.

3. *Spinal Symptoms*.—Arthropathia tabica, benign or malignant; during the initial stages only benign and painless; visceral neuralgia; nervous dyspepsia; copious and frequent vomiting; gastric crises; watery diarrhoea; weakness of the detrusor of the bladder; retention of urine; rapid appearance of impotence, sometimes with increased sexual desire; transitory paralysis of the limbs from a degenerative inflammation of the peripheral nerves.—*Wien. Med. Presse*, 5, 1890.

**PYOPNEUMOTHORAX AND SEROPNEUMOTHORAX**.—Prof. Leyden, at the meeting of the Berlin Medical Society, presented a man on whom he had operated eighteen months before, on account of a tubercular pneumothorax, and who had been so far restored to health that he was able to follow his daily business. The patient had followed hygienic precautions. He now had only a small fistula, which did not trouble him. For some time there was albuminuria and swelling of the spleen, so that amyloid degeneration of the latter organ was feared. Both of these conditions have, however, disappeared. Leyden did not think that seropneumothorax was as amenable to treatment on account of the adhesions which form between the lungs and thoracic walls.—*Berliner Klin. Wochenschr.*, 2, 1890.

**CONNECTION BETWEEN MENTAL ALIENATION AND AFFECTIONS OF THE EYES**.—Royer examined two hundred and fifty lunatics with hallucinations, and found only one hundred and ten whose eyes were normal, or who presented only slight defects. One hundred and forty, or fifty-six per cent., showed hallucinations of ocular origin in relation to sensibility or localization. In relation to the former, he elucidated that the patients saw badly, at least in one eye. He also learned that ocular hallucinations are more frequent in the evening and at night. The right eye was the more frequently affected of the two, and in cases in which both eyes were involved the condition was most aggravated in the right one. Many of those in whom the left eye was affected were left-handed.—*Bulletin Med.*, 10, 1890.

**DEGENERATION OF THE SPINAL CORD IN PERNICIOUS ANEMIA**.—Prof. Lichten has made autopsies in several cases of pernicious anemia, and in every instance could demonstrate changes in the spinal cord. These changes consisted of either small hæmorrhages of minute sclerotic foci emanating therefrom, or extensive degenerations of the posterior columns, radiating to other parts of the spinal cord. He regards the degenerations as sequelæ of the anemia, as in a case of leucæmia the same changes were found, and which were absent in a case of pseudo-leucæmia and chlorotic anemia with fatal issues. Similar changes were found in a case of grave icterus.—*Münch. Med. Wochenschr.*, 3, 1890.

**AN UNUSUAL CASE OF NICOTINE POISONING**.—A merchant while shaving himself inflicted a slight wound on the lower lip. Not minding the trivial injury thus occasioned, he shortly afterwards smoked a cigar. During the following night the lower portion of the face became very much swollen. No treatment availed, and he died after great suffering. His attending physician believed that in smoking some nicotine was absorbed by the wound.—*Med. Neugier*, 9, 1890.

(Cases of nicotine poisoning are rare. Blythe, *On Poisons*, vol. i., p. 245, relates only three cases of poisoning by nicotine. There were frightful tetanic convulsions, widely dilated pupils, irregular action of the heart, and diarrhoea. Pure nicotine acts with as great rapidity as does prussic acid. Excessive muscular prostration, difficult breathing, tetanic cramps, diarrhoea, vomiting, with irregular pulse, represent both tobacco and nicotine poisoning. Six milligrammes of nicotine will cause dangerous symptoms in the adult. The cause of death is paralysis of the respiratory centres.—S. L.)

**POISONING BY BAD POTATOES**.—Twenty-three soldiers in Lyons were taken ill with symptoms resembling those of belladonna poisoning. They all complained of headache, fever, great debility and diarrhoea; some also of dizziness, nausea, dilated pupils; others had tinnitus aurium, defective vision with photophobia, and partial spasm. It was found that these men had all partaken freely of unripe new potatoes, which on examination were found to contain a large quantity of solanin. Experiments on the lower animals with the same potatoes produced similar poisoning symptoms.—*Allgem. Med. Centr. Zeitung*, 21, 1890.



**THE USE OF ALKALIS IN GASTRIC TROUBLES.**—When the patient suffers from hyperacidity, the alkalis must be given after a meal, two or three hours afterwards when the acidity has reached its maximum. Large doses are here necessary, three to four grammes of bicarbonate of soda dissolved in some hot beverage. When, on the other hand, the patient is troubled with a diminution of hydrochloric acid, as in the case of the dyspepsia of neurasthenic and anæmic patients, the alkaline waters must be administered in small doses, and before meals, as given thus they favor the secretion of the gastric juice.—*Semaine Medicale*, 12, 1890.

**"PERIHEPATIC RUBBING" AND ABSCESS OF THE LIVER.**—Large hepatic abscesses usually have their seats in the central portion of the gland. When they come, through progressive development, in contact with the superficial layers of the parenchyma, they often provoke, if not always an adhesive peritonitis a perihepatitis, which shows itself during examination by auscultation, as a perceptible sound of rubbing, and by palpation over the right hypochondrium at a level of the seventh or eighth intercostal space on the anterior axillary line. It may be called "*frottement peritoneal*;" it confirms the diagnosis. It is not only a proof of the existence of hepatic abscess, but it shows that adhesions have formed. At the spot where the greatest rubbing is heard, there will also be parietal œdema. It is here that the exploratory puncture should be made.—*Bulletin Med.*, 19, 1890.

**ASCENDING VENOUS PULSE.**—Dr. Benno Holz (*Berlin. Klin. Wochens.*, No. 50, 1889) recently described a case of this very rare phenomenon before the Berlin Medical Society. It occurred in a patient suffering from pseudo-leukæmia.

A lady, aged 56, had come under Dr. Holz's care six months previously for great pallor, emaciation, and weakness. She complained of pains in the right thigh and hip and over the sternum. The glands in the neck, groin, and axilla were swollen, soft and tender, and over the sacrum and tibia there was slight œdema which was looked upon as cachectic. Patient had slight dyspnoea. There was no trace of albumin in the urine and no alteration in quantity. On the other hand there was a characteristic rich secretion of uric acid. The pulse was hard, full, and powerful, but no hypertrophy of the left ventricle could be made out. There was no alteration in the heart sounds. One morning the patient became suddenly delirious, had violent vomiting, and shrieked, and threw herself about. She appeared to have severe pain in the neck and head. For twenty-four hours she was very unruly, and then became comatose. During this time she showed a peculiar variation of Cheyne-Stokes breathing—what Dr. Holz calls the descending phase of the phenomenon. There was no gradual rise, but after a longer or shorter pause, the respiration began with great intensity, assisted by the extraordinary respiratory muscles, with spasmodic abduction of the lower jaw, twitching of both arms, and shaking of the whole body—the contracted pupils dilating suddenly. After several respirations, becoming less deep, the pause set in. At the outset of the phase the frequency of the pulse rose, the artery became fuller, and the wave higher; with the respiratory decline the pulse fell, fulness decreased, and the heart appeared at a standstill until the respirations began again. Œdema of lungs gradually developed, the patient becoming cyanotic and developing stertorous breathing.

For the cardiac weakness an injection of camphor was made and unexpected results followed. Half an hour after, the breathing altered, the pulse became regular, unusually hard and full, and the wave high. There was no capillary pulse in the cyanotic finger-points, but one saw in the well-filled, distended and tense veins of the hands and forearms a strong post-systolic pulse, ascending from below upwards, that is centripetally. It extended no further than the upper arm from the tip of the hand, no trace of it being seen in the jugulars. This pulse was plainly visible and palpable, the wave running upwards. Constriction of the brachial artery, as well as compression of the peripheral veins, caused it to disappear, while central pressure on the veins had no effect. This phenomenon lasted an hour, and death ensued on the following day.

At the necropsy, lymphomata were found in the internal organs, as also hypostatic pneumonia and cardiac hypertrophy, but no valvular disease, the arterial system being intact. There was no arterio-sclerosis. The kidneys were atrophic and granular, and the brain showed œdema and hyperæmia. In this case we had contracted kidneys, with normal urine. This would explain many of the symptoms. The great congestion in the venous system led to œdema of the lungs. Under these circumstances, the heart was disabled, when it received the camphor injection which acted as a powerful stimulant.

The heart worked with renewed force, the right ventricle increasing the stagnation in the lesser circulation and the œdema of the lung, the left chamber endeavoring to overcome the positive pressure in the capillaries and veins and in this manner rendering possible the passage of the high pulse-wave from the arteries, through the capillaries into the veins. Such, according to Dr. Holz, is the most feasible explanation.—*The Practitioner*.

**TREATMENT OF GRAVES'S DISEASE.**—Professor Nothnagel, of Vienna, in the course of a clinical lecture on Graves's disease, summarizes the treatment as follows:

Digitalis, according to common experience, does not act at all on the tachycardia. It requires some firmness not to give this drug, but we may with comfort abstain from doing so, for it does no good. The same observation applies to the other remedies that act in the same way as digitalis. An effective agent against the palpitation is cold, in the form of an ice bag either over the cardiac region or over the neck.

In some cases the palpitation, restlessness and excitement are made to disappear or are diminished by the application of cold to the neck sooner than over the cardiac region. These patients ought to live quietly, and to avoid coffee, beer, cigars, and mental and bodily excitement. Little or nothing is to be expected from medicinal remedies. According to the most recent observations, galvanism through the medulla oblongata and cervical sympathetic is the best treatment; but this treatment must be regular and long-continued, and should be associated with a hydrotherapeutic course; the patient is then systematically treated in a cold-water institution, with tepid half-baths, irrigations, wrapping in moist linen-cloths wrung out, and the cold spinal bag. By this means, along with the mental quietness, an improvement in the condition is, in many cases, brought about. Iron can be given, if indicated; in other cases, when patients are much excited, bromide of sodium, or potassium, may be exhibited in doses of fifteen grains, twice or thrice daily. An important means of treatment, but one that can only be carried out in the cases of well-to-do patients, is to send them to the mountain regions, especially to the higher altitudes. By such a sojourn, many cases are considerably benefited.—*The Practitioner*, March, 1890.

**ON THE ASSIMILATION OF COD-LIVER OIL, LIPANIN AND BUTTER IN HEALTHY PEOPLE.**—Dr. Grégory I. Gübkin, of St. Petersburg, has made inquiry into a comparative assimilability of cod-liver oil, lipanin and ordinary butter. The experiments were conducted on six healthy young men (medical assistants and students), æt. from 20 to 27, and lasted in each case for fifteen days, during the first of which the person experimented upon was taking butter (in the daily dose of 60 grammes containing 52 grammes of fat); during the next five days, Kahlbaum's lipanin, which is a pure olive oil, with 5 per cent. of a free fatty acid (in the daily dose of 52 grammes), and during the last five-day period, Bergen white cod-liver oil (in the daily dose of 52 grammes). The outcome of Dr. Gübkin's investigations may be summed up thus:

1. The average assimilation of butter amounts to 97.3 per cent. (of the quantity ingested); that of lipanin, 97.21; and that of cod-liver oil, 97.12.
2. Therefore, butter is assimilated best of the three fatty substances, the second place is occupied by lipanin and the last by cod-liver oil.
3. Accordingly, the prevailing view, attributing to cod-liver oil quite a peculiar assimilability, proves to be incorrect.
4. Hence, the oil can be safely substituted by ordinary butter, which, in addition, is by far a cheaper and more savory article.
5. Lipanin, while being expensive, does not offer any advantages over cod-liver oil, more especially over butter.
6. The view, according to which the admixture of free fatty acids to neutral fats increases assimilability of the latter, cannot be supported by experiment.—*The Provincial Medical Journal*, April, 1890.

**THE PATHOLOGICAL ANATOMY AND THE MODE OF DEVELOPMENT OF MITRAL STENOSIS IN CHILDREN.**—Dr. A. Ernest Sansom, London, has analyzed forty cases in which the physical signs indicated mitral stenosis, and nineteen records of post-mortem examinations, occurring in children only of twelve years of age and under, for the purpose of elucidating the pathological problems connected with mitral stenosis. The post-mortem evidence he considers sufficient to warrant the following conclusions: 1. Mitral stenosis is not a congenital formation. 2. Mitral stenosis

is intimately associated with endocarditis. The doctor is not aware of a single recorded case in children wherein a stenosed mitral orifice was observed apart from endocarditis. He considers that if mitral stenosis were a congenital malformation, it would probably be observed in cases of congenital cyanosis; such is not the fact. Nor is it met with in cases of congenital anomaly, except as a result of foetal endocarditis. Constriction of the mitral orifice is scarcely ever met with until the age of five years. The smooth, even, regular membranous funnel-shaped aperture is probably due to a slow process of welding and thickening of the mitral curtains, and not to a congenital error of development. In reviewing the data from the fields both of pathological anatomy and of clinical observation, Dr. Sansom concludes that the morbid process which results in the constriction of the mitral orifice commences with endocarditis which, in the great majority of cases, is of the rheumatic form. It is, however, a *limited* endocarditis, and the consecutive changes are comparatively slow. In the endocarditis which usually accompanies well-defined acute rheumatism the area involved in the inflammatory changes is considerable. The endocardium of the auricle and ventricle, the curtains, cords and columns of the mitral valve, and oftentimes the neighboring myocardium are infiltrated with the products of inflammation. In the later stages fibroid changes occur with shortening of the cords and columns and retraction of the mitral curtains, so that regurgitation is the result. When the endocarditis is of slighter intensity and more limited, the inflammatory changes chiefly involve the mitral ring or its auricular aspect; the process spreads gradually from thence to involve the curtains, cords and columns, which slowly undergo the changes of welding together and fibrous transformation. In the great majority of cases the form of endocarditis which initiates these changes is that which we find associated with rheumatism, though the other obvious signs of the rheumatic state may be extremely slight or even non-existent. He considers it is at least possible that a form of endocarditis, sometimes met with in cases of chorea, where the granulations are not friable and not associated with inflammatory infiltrations, but are firmly adherent and seem like fibrous outgrowths of the endocardium may have its origin apart from rheumatism. The most probable cause to effect this in childhood is violence done to the valve-structure during the tumultuous action of the heart, brought about by nervous excitation.—*Amer. Jour. Med. Sci.*, March, 1890.

**THE TREATMENT OF HABITUAL CONSTIPATION.**—In speaking of the treatment of chronic constipation, Nothnagel says that the removal of the symptom itself does not suffice; the cause of the trouble must be relieved, and this is tardy peristalsis of the intestines. Massage of the abdomen by diverse measures, as rubbing, kneading, palpation, hammering, etc., is the chief therapeutic measure. It makes no difference whether one begins these manipulations at the sigmoid flexure of the colon and works upwards, or whether he commences at the lower end of the ascending colon and works towards the other end. To be effectual, massage must be persisted in for weeks and months. Though it may occasionally yield good results in some patients after a few weeks, it is yet advisable, before instituting treatment, to let the patient know that a long period of time will be necessary before he can be pronounced cured. Many a case is benefited by the use of auto-massage at the time of defecation.

Another valuable therapeutic measure is faradization of the abdomen, which Nothnagel prefers to galvanization, as advocated by Lenbuscher, in which one electrode is introduced within the rectum, and the other is placed anywhere on the surface of the abdomen. In faradization both electrodes can be used on the outside. Steady regular walks should be advised; during inclement weather in-door gymnastics must be practiced. The patient must not lose courage too soon; time and patience are necessary in order to get all the benefit possible from massage, faradization and gymnastics. Let such patients drink a glass or two of cold water, or of some mineral water, in the morning before breakfast, till their bowels become more regular. Purgatives must never be relied upon. Enemata may be used. Small glycerine injections tend to make irritable patients more tractable.—*Wien. Med. Presse*, 10, 11 and 12, 1890.

**HOW DOES ALCOHOL AFFECT THE FUNCTIONS OF THE STOMACH OF HEALTHY PERSONS?**—Dr. Glumensau comes to the following conclusions concerning this subject: 1. At the beginning of digestion the activity of the gastric juice diminishes, which can be noted especially in persons unused to alcoholic beverages. 2. The effect of strong alcoholic solutions is more decided. 3. While in the first three

hours of digestion a retardation takes place, a compensation and increase happens from the fourth to the sixth hour, the quantity of HCl increases 1 to 2 per cent. above the normal. 4. The gastric juice during these hours possesses an increased power of digestion. 5. The secretion of the gastric juice lasts longer and is more copious during the use of alcohol. 6. The action of the pepsine is not suspended, although at first a diminution of the coagulation of the milk may be observed. 7. The motor power and the capability of absorption of the stomach are also reduced, just in proportion to the strength of the alcoholic solution.—*Allgem. Med. Centr. Zeitung*, 20, 1890.

**GASTRIC NEURASTHENIA, AND ITS TREATMENT.**—The patient, with gastric neurasthenia, complains of diverse nervous symptoms, such as sensation of general debility, cold extremities, a change of character, hypochondriasis, melancholy, sleeplessness at a certain hour of the night and general decrepitude; there are no prominent hysterical stigmata. In relation to the intestinal canal, one meets tardy digestion; the patient complains of flatulency; diarrhoea alternates with constipation, the latter prevailing; the feces have an enormously fetid odor, sometimes enteritis mucosa; appetite capricious. Physical examination reveals a dilated stomach, a movable kidney, enlarged liver, cold extremities, swelling of the phalangeal joints. Beard, years ago, spoke of a nervous dyspepsia from exhaustion. This Levan ascribes to an irritation of the nerve-cells of the solar plexus. Glénard considers these manifestations to originate in enteroptosis, a change in the mutual positions of the different intestinal tracts, especially a prolapsus of the ascending colon and of the first part of the transverse colon. The mobility of the kidney is only a consequence of the prolapsus of the colon. Bouchard explains these symptoms by the longer continuance of the food in the stomach, causing fermentation and formation of ptomaines, which are absorbed by the intestines and cause manifestations of auto-intoxication. Dujardin-Beaumetz believes in the humoral theory and anti-sepsis, and prescribes the following: *R.* Bismuth salicyl., naphthol.  $\alpha$ , carbo veg.,  $\bar{a}$  10.0, to be divided into thirty powders; a powder after breakfast and dinner, and saline mineral water a glassful, to be taken before retiring. Where there is diarrhoea, he prefers injections with antiseptic solutions (boracic acid, 1 per cent., or naphthol  $\alpha$ , 1 per cent.) Of the greatest importance is the diet; a meal only every seven hours, and nothing whatever during the intervals; neither solids nor drinks should be ordered. Vegetable diet; greens, fruit, only slightly boiled eggs, very little drinks, meat only in moderate quantity and well done, no sparkling waters or wines, and no liquors. Hydrotherapeutic treatment and systematic muscular exercises will reduce the irritability of the nervous system.—*Wien. Med. Presse*, 10, 1890.

[We have found in such cases, *argentum nitricum* 30, carbo veg. 30–200, the too-much neglected *carduus marian.*, *helonias* and *hydrastis* often of more benefit than the handy *nux vomica* or *pulsatilla*. Bismuthum has disappointed us in several cases where we thought it indicated from the pain going from stomach through to spine.—S. L.]

## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

**THE OPERATIVE TREATMENT OF RETROFLEXION OF THE UTERUS.**—Dr. Frommel refers to the investigations of B. S. Schultze regarding the effect of the utero-sacral ligaments in supporting the uterus, and relaxation of them in posterior uterine displacements. Professor Frommel proposes to shorten these ligaments as a cure for such deviations and performs it in the following manner: The vaginal pouch posterior to the uterus is exposed. A catgut ligature is applied near the insertion of these ligaments to the uterus, and to the peritonæum of the lateral pelvic wall. When tied this suture carries the cervix upwards and backwards. He claims a successful case operated on in this manner.—*Centraltblatt für Gynäkologie*, No. 6, 1890.

**THE TREATMENT OF RACHITIS WITH SMALL DOSES OF PHOSPHORUS.**—Dr. Mandelstamm during the past two years has treated two hundred and fourteen rachitic patients of various ages. One hundred and twenty of these were cured; forty-three improved and among thirty of the latter cases this medicine could not be employed on account of other diseases. Five of these patients died. The children took phosphorus for months or even a year. A mixture was made of one centigramme phosphorus to one thousand grammes cod liver oil (5x dilution). A dessertspoonful was given once or twice a day. After two months' treatment the cranial bones became firmer, the fontanelles and sutures smaller, the nervous attacks and spasms of the glottis less frequent and weaker, the patients gained in weight and there was general improvement. The writer had seen no unpleasant effects from the medicine. He is of the opinion that phosphorus has a good effect on the disturbances of the stomach accompanying rachitis, but if patients suffer from intestinal catarrh with flatulent distension, this disease must be cured before phosphorus can be used.—*Bullet. Génér. de Thérap.*

**STATISTICS FROM MATERNITÉ DE LARIBOISIÈRE.**—In 1888 there were 2267 births; 15 deaths, among these 8 from puerperal infection; 63 forceps, 12 versions, 5 basiotripsies, 1 cephalotripsy, 3 embryotomies, 20 induced premature labors. In 8 cases of infection, 3 were infected before admission to the hospital.

In 1887 there were 2177 births, 10 deaths, no case of puerperal fever, 49 forceps, 10 versions, 3 basiotripsies, 4 embryotomies, 9 induced premature labors. The statistics of operations from 1883 to 1888 are: 277 forceps deliveries with 10 deaths, 6 of these from puerperal fever; 68 versions, 5 deaths, 3 from rupture of the uterus, 2 from infection; 10 cephalotripsies, 2 deaths from infection; 32 basiotripsies, 4 deaths, 2 from infection, 1 rupture of the uterus; 7 embryotomies, 3 deaths, 2 ruptures of the uterus and 1 from infection.

Laparotomy was performed once for abdominal pregnancy. The entire mortality of this period is 0.74 per cent.; the mortality from septicæmia alone 0.39 per cent. It is interesting to note that Pinard drops lemon juice in the eyes as a prophylactic against ophthalmia neonatorum in preference to Credé's method, but does not give his reasons for it.—*Centralblatt für Gynäkologie*, No. 6, 1890.

**THE PATHOGENETIC ACTION OF A MICROBE FOUND IN THE URINE OF ECLAMPTIC PATIENTS.**—Interested by the observations of Dr. Doléris, Dr. Blanc found microbes in the urine of patients suffering from eclampsia which he did not find in the blood; as late as the fourteenth day after the attack gelatine cultures could be made from the urine. No microbes possessing the same peculiarities could be found in urine of women who did not suffer from albuminuria. He made experiments with pure cultures on pregnant and non-pregnant animals, both of which had eclamptic attacks and albuminuria which apparently depended on an epithelial nephritis. He sums up the effects of these experiments as follows:

1. General convulsions; in rabbits death ensued soon after the convulsions. Pregnancy in these animals is a predisposing cause.
2. Inflammatory swelling at the site of injection in those animals surviving the primary effects, which soon passed into gangrene. In case of recovery the animals acquired a certain immunity.
3. Millitary abscesses, phlebitis, rise of temperature.
4. Diseases of the kidney of various degrees of severity and albuminuria.—*Lyon. Méd.*

**PUERPERAL INFECTION.—PHLEGMASIA ALBA DOLENS.—ERYSIPELAS.**—Dr. F. Widal believes the streptococcus pyogenes is the common cause of infection in puerperal fever. In the latter disease its effects may be localized in the uterus, or general in the system. He does not believe that the so-called diphtheritic form of puerperal fever has anything to do with diphtheria, but to the pus containing this streptococcus. Phlegmasia alba dolens, he thinks, is always due to infection of the endothelium of the veins with this streptococcus pyogenes, causing thrombosis. Erysipelas also furnishes the same streptococcus. He had succeeded in producing erysipelas in rabbits by inoculation from a patient who had died from puerperal fever.—*Centralblatt für Gynäkologie*, p. 64, No. 4, 1890.

**THE EFFECT OF INFLUENZA UPON PREGNANCY AND THE PUERPERIUM.**—Pregnant women enjoy no immunity from influenza, but the attacks seem to run a lighter course in them. Only in severe cases is the course of the pregnancy inter-

rupted by that disease. In the latter case, it causes death of the fœtus (which may be retained for several weeks) or premature birth ensues. The influence exerted by influenza on the course of labor is to make the pains stronger, but they are more ineffectual; the labor is hence tardy, and the lives of mother and child are endangered. If influenza is present before labor, then relapses are apt to occur afterwards. Involution of the uterus is stopped during the course of the fever, and the lochia assumes a foul odor. Hæmorrhage from the uterus occurred in several cases. In only two cases did the infants suffer simultaneously with the mothers.—*Münch. Med. Woch.*, 10, 1890.

**POST-MORTEM CÆSAREAN SECTION.**—A woman seven months pregnant was brought into the hospital suffering from basilar meningitis. During the three days of her stay in the hospital, her temperature oscillated between 103° and 105°. On the fourth day she died. During the three days she lived in the hospital the induction of labor was contraindicated by reason of her low state. While she was dying, everything was gotten ready for laparotomy immediately after death, which operation was performed twenty minutes later. The asphyxiated child breathed after the performance of the usual manipulations, and cried with a weakly cry, and lived for twenty-one hours. The immediate cause of death was debility; one may well affirm that had the child been born at full term it would have survived. This case fully justifies the performance of the Cæsarian operation in other similar cases.—*Wiener Med. Presse*, 11, 1890.

**SUTURING OF THE RETROFLEXED UTERUS TO THE ANTERIOR ABDOMINAL WALL.**—Leopold has fully demonstrated the practicability of this method in ten cases. He finds it indicated in salpyngotomy, on account of chronic oöphoritis and salpingitis, whether the retroflexed uterus is adherent or not, after removal of tumors which kept the uterus permanently in a position of retroflexion, and, in pure retroflexion of a movable uterus, when all the suffering emanates from it, and when all other methods of treatment have failed.—*Wiener Med. Presse*, 10, 1890.

**HOW TO WASH OUT A BABY'S STOMACH.**—Dr. A. Seibert gives the following directions for performing this little operation: A No. 10 A soft catheter is attached to a glass tube six inches long; the operator is seated before the child, which is held upright (as in throat inspection), or on one side when collapsed; the left index finger of the operator is held between the right upper and lower maxillæ so as to prevent the mouth from closing. Then the tube is passed over the tongue into the pharynx, the head of the child inclining slightly forwards. By gentle pressure we overcome the spasmodic contraction of the upper pharyngeal muscles, and then the catheter glides easily into the stomach. Now, the left hand holds the catheter and the right attaches the lower end of the tubing of the fountain syringe or regular irrigator over the glass tube attached to the catheter. Water is now allowed to flow, and after the stomach is filled the supply is shut off, the tube detached, and the end of the glass tube lowered below the child's umbilicus, so the contents come away very nicely. Never use force. No trained assistant is necessary. The tube will never enter the larynx. The younger the babe the easier it is to wash out its stomach.—*The Dixie Doctor*, April, 1890.

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## OPHTHALMOLOGY, OTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

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**THE USE OF FLUORESCINE AS A MEANS OF DIAGNOSING LESIONS OF THE CORNEA.**—In a paper read before the Johns Hopkins Hospital Medical Society, Dr. R. L. Randolph says: In the November and December numbers of the *Centralblatt für Practischer Augenheilkunde*, is to be found an article by Dr. Thomalla, of Friedland on coloring the cornea with fluorescine, as a means of diagnosing or detecting lesions of this portion of the eye. According to the author, Dr. Staub, a Netherlands army surgeon first discovered the fact that a solution of fluorescine when dropped upon a portion of the cornea, which was deprived of its epithelium, would

color this spot a deep green and leave the rest of the cornea unchanged. For the past two months in the eye clinics of the Johns Hopkins Hospital and the Presbyterian Eye and Ear Hospital he has been testing the value of this method of diagnosing corneal lesions. The experiments number over a hundred and led me to positive conclusions.

Fluoresceine is a red powder soluble in water and belongs to that class of substances which are found as products of coal tar distillation. "I employ a solution of 10 grains of the powder to the ounce of water, to which is added 15 grains of the bicarbonate of soda. I have never known the solution to have an irritating effect, and I have used it in most intense forms of corneal inflammation. The portions of the cornea stained retain the color from half an hour to several hours. The solution produces not the slightest impression upon the healthy cornea. I have always found that when positive defects in the corneal epithelium existed, in other words where there was actual loss of substance, the coloration was more apparent. So long, then, as it is possible to color any portion of the cornea, we may be certain that some lesion still exists."

In excoriations of the cornea, positive results were the rule. In ulcers of the cornea positive results were always obtained. In simple superficial keratitis the coloration was much less distinct than when this disease was associated with an ulcer. In parenchymatous keratitis, the results were invariably negative. In three cases of iritis uncomplicated with corneal trouble I failed to obtain any coloration. In two cases of iritis of syphilitic origin, where the cornea was involved, superficially as well as interstitially marked coloration was observed. In two cases of acute glaucoma the result was absolutely negative. In cases of foreign bodies in the cornea, no matter how small the foreign body was, its position and size was located to a nicety. Here the coloration was immediate and distinct, showing itself by a green ring around the foreign body. In phlyctens of the conjunctiva, the color was rather yellow than green. Only in those cases where the phlycten was located on the limbus of the cornea and the latter had been involved to some extent was there any positive green coloration to be seen. Pterygia and pinguecula, gave negative results. With the exception, then, of phlyctenular conjunctivitis the solution is inapplicable to any of the other forms of conjunctival inflammation.—*Johns Hopkins Hospital Bulletin*, April, 1890.

**ABSORBING CATARACTS.**—Dr. Kalish, before the New York Academy of Medicine (*Medical Record* of March 29th), claims that he has discovered a measure by which in certain cases, incipient cataracts may not only be checked in their growth, but also in great measure absorbed. Two drops of a mixture of equal parts of glycerine with a 1 per cent. solution of carbolic acid in rose water, are instilled into the eye, and with the patient seated in a chair having a back high enough to support the head. The operator standing or sitting behind the patient, places both hands over the closed eyes, so that the tip of each middle finger rests upon the eyeball at its nasal side, the index and ring finger falling into place beside the middle finger. With slight pressure upon the eyeball, the three fingers are drawn outward over the eye to the temporal side. This procedure is repeated twenty to thirty times a minute, the stroking being in one direction only, and continued for ten minutes, when a second instillation of two drops into both eyes should be made, manipulation carried on as before for ten minutes. This treatment is to be continued daily for a week, and then the interval between the instillations lengthened to fifteen minutes, making the treatment three quarters of an hour in duration. The eyes should now be treated every other day and this kept up for three or four months. He has found that instillation alone had no beneficial effect; such, also, was his experience with manipulation alone. The treatment cannot be left to an unskilled assistant but must always, the doctor claims, be carried out by a practiced hand. In the six cases reported, there was at first an increased tension noticed, which however, was noticeably decreased by the manipulations.

**INDICATIONS FOR AND AGAINST TRACHEOTOMY IN CROUP.**—It is not a question of how many hours shall we wait, because some cases run their course with alarming rapidity, while others move comparatively slowly. If in spite of treatment there is no improvement, and if the cough remains unchanged, and stridor increases do not persist in treatment, do not wait for restlessness and lividity and dyspnoic attacks, but operate without further delay. If you have decided that tracheotomy is called for and the parents plead for postponement, and after it may be many

hours, when the child is moribund they give their consent, do not refuse, but do not be eager to operate. It will give you great anxiety, it will cause you endless trouble, and in the end it will almost certainly die. Bronchial croup, shown by the expectation of little bifurcating tubes of membrane; severe pneumonia, or capillary bronchitis, shown by rapid breathing, contraindicate operation, but the milder forms do not. Extreme prostration without evidence of asphyxia, contraindicates. If the case is of laryngeal and pharyngeal diphtheria, I should say do not be in a hurry to operate. If "those classed as diphtheria mostly die," it may be taken as an argument on the one hand in favor of early operation, and on the other in favor of late operation. Rose Cormack says in many benignant cases the false membrane begins to loosen spontaneously and to be gotten rid of between the fifth and seventh day.—*Times and Register*—Denby in *Med. Press and Circular*.

**THE RELATION OF REFRACTION AND INSUFFICIENCY OF THE OCULAR MUSCLES TO FUNCTIONAL DISEASES OF THE NERVOUS SYSTEM.**—The conclusions reached by Dr. D. B. St. John Roosa, after a lengthy article devoted to this subject, are :

1. The eyeball of the human race is very rarely in what might be defined as an entirely emmetropic condition.

2. Perfect equilibrium of the ocular muscles, is by no means a common condition even among persons of sound health and without asthenopia.

3. Defects in these two states by no means necessarily produce even local disturbances, such as are comprehended under the term of asthenopia, inflammation of the edges of the lids, etc., although high degrees of hypermetropia, moderate degrees of astigmatism and all cases of mixed astigmatism are apt to do so, sooner or later.

4. Asthenopia depends chiefly upon two sets of causes, nervous exhaustion and uncorrected errors of refraction.

5. In estimating the influence of these defects, great stress should be laid upon the general condition, and the line sharply drawn between asthenopia due to exhaustion and that to faulty refraction.

6. Nothing has been added essentially to Donder's discovery of the fundamental cause of accommodative asthenopia, except that astigmatism forms a more important factor in its etiology; muscular asthenopia falls into the background, while the definition of asthenopia has been much amplified by ophthalmologists.

7. The origin of a class of such diseases, as chorea, epilepsy and hystero-epilepsy, has not been found in errors of refraction, nor in insufficiencies of the muscles of the eyeball.

The observing general practitioner is able to test the truth of this latter proposition as he looks among the neurotic families and individuals of his acquaintance, and observes whether or not the use of glasses and ocular tenotomies are beginning to lessen the cases of chorea and epilepsy. Certainly a discovery, which it was predicted would vie with those of Jenner and Lister, has been proclaimed with sufficient fulness and clearness, and has been acted upon in an arena large enough to allow us to judge by this time whether it is an advance in rational and scientific therapeutics. I do not believe that it is, but that the theory of the ocular origin of nervous disease, by distracting attention from the evident, and in some instances preventable, causes of neuroses, has delayed our progress and inflicted serious damage to the reputation of our profession for accurate observation and philosophical conclusions.—*New York Medical Journal*, April 19, 1890.

**ELECTROLYSIS IN GRANULAR LIDS.**—The eyelid is everted and a small electrode connected with the negative pole is moved slowly over the unhealthy mucous membrane. The positive pole is placed at the nape of the neck. The electricity should be applied for several minutes, and will require to be repeated six or eight times.—*Wood's Medical and Surgical Monographs*, March, 1890.

**ELECTROLYSIS FOR STENOSIS OF THE LACHRYMAL CANALS.**—A probe, small enough to be inserted into the punctum is introduced and passed along to the nasal duct. The probe is fitted into a handle and is attached to the negative pole of a battery. A flat-plate electrode, covered with some substance which will retain moisture, is connected with the positive pole, and generally placed on the back of the neck beneath the collar, having been first moistened with salt and water.

The handle of the negative electrode possesses a mechanical arrangement for completing the circuit. Four cells of a Stohrer's battery will usually be found sufficient, with the resistance they have to overcome, to give a current strength of four



milliamperes. A Leclanche battery will do equally as well for such a small operation, but perhaps one or two more cells would have to be used. With a current strength of four milliamperes, the enlargement of the canaliculus takes about thirty seconds. No anæsthetic is necessary. During the operation, a little froth collects beside the electrode and oozes out of the punctum. In a very few seconds after the circuit is closed, the probe, which was first gripped tightly in the canal, can be made to move backward and forward along the passage with great ease. The probes used should never be greater than 1.5 millimetres. The advantages attending the treatment by electrolysis, are chiefly due to the fact that so little displacement or alteration of the normal channels is effected, and by it we have the means of increasing the lumen of the puncta and canaliculi, without any excessive stretching.—W. E. Steavenson, *Wood's Monographs*, March, 1890.

**INTENSE PHOTOPHOBIA CURED BY DIRECT ANÆSTHESIA OF THE CASSERIAN GANGLION.**—A child of 18 years of age came under treatment with phlyctenular keratitis in August last; and in November last the other eye became affected in the same way. All efforts to raise the lids in order to inspect the cornea were unavailing, and gave rise to fits of sneezing. The photophobia was intense. Gutierrez-Ponce, under whose charge the patient was, then endeavored to anæsthetize the Casserian ganglion by introducing into the external auditory meatus a small plug of cotton impregnated with chloroform, with the result that almost immediately the patient allowed the lids to be raised without a protest and without a sneeze. The same treatment was repeated on subsequent occasions, and was attended by the same success. The author concludes that the external auditory meatus affords a ready means of bringing remedies to bear in ocular affections of nervous origin.—*London Medical Recorder*, March 20, 1890.

**THE SHAPE OF THE NOSE IN TRUE OZENA.**—Most authors who have written on the subject of true ozena have noticed that the nose in subjects of this malady is very often flat and of the so-called saddle-back shape. Some have attributed to this form of nose a predisposing influence in the production of this disease, and its origin has been set down to scrofula, or to a mere caprice of nature. Dr. Potiquet believes that to the form of nose is really due the slowly progressing pathological process of atrophic rhinitis which precedes, prepares the way for, and accompanies ozena. The author endeavors, in the course of his paper, to establish the following propositions: 1. It is not true, as has been pretended, that the flattened form of nose predisposes to true ozena. 2. The flat saddle-back nose, which has been noticed as a frequent accompaniment of true ozena, is mostly due to the atrophic rhinitis which precedes and accompanies the ozena. 3. The nose in ozena takes, or rather preserves, the flat form, in those cases more especially in which atrophic rhinitis has set in during infancy. 4. The adult sufferer from ozena has, as a rule, not got that shape of nose which he should have had according to the laws of heredity. 5. The sufferer from ozena very often does not possess the form of nose which his cranial conformation entitles him to.—*London Medical Recorder*, March 20, 1890.

**CAUTERIZATION OF THE TURBINATES FOR HYSTERICAL APHONIA.**—Dr. W. E. Casselberry, after citing authorities and illustrations as reminders of the established fact, that nasal irritation is capable, under certain conditions, of exciting muscular action in the larynx, goes on to say that this rule might be worked the other way, and the correlation between the nerves of these organs utilized, therapeutically, to correct functional laryngeal paresis by artificial irritation applied to the nasal tissues. Two illustrative cases are given. In the first, there was marked debility, but no manifestation of hysteria. The inferior turbinated bodies were much hypertrophied, and one or the other nostril constantly occluded. The vocal cords were flabby and paretic, but with no local cause apparent in the larynx. Ordinary treatment proving useless, the electro-cautery was applied to the inferior turbinates, burning a line four centimetres in length, and in depth to the bone. After the second cauterization, the voice returned permanently.

In the second case, there were signs of pulmonary lesion, without tuberculosis. The paresis was associated with only slight congestion of the larynx. There were present hypertrophic rhinitis, follicular pharyngitis and chronic tonsillitis. Constitutional treatment and local applications failed to improve. As in the first case, the voice was permanently restored after the second electro-cauterization of the turbinates. Few cases described as "hysterical aphonia," belong strictly to that cate-

gory. Gerhardt thinks some of them belong to the class of "reflex" paralysis; more often, it is the simply anæmic, and those debilitated by phthisis, independently of laryngeal tuberculosis, who suffer from functional aphonia. It follows inflammation and laryngeal rheumatism from "cold," in which case the congestion disappears, but the aphonia remains indefinitely.

The defect may lie in a perverted distribution of nerve-force to the parts, or there may exist a state of inherent muscular weakness, requiring increased nerve-force for action, which is, in debilitated subjects, not forthcoming. Whichever it may be, if we can stimulate energetically and somewhat continuously the branches of the pneumogastric nerve which supply the larynx, it would seem possible to restore their flagging energies, or to re-direct the perverted nerve-force into their proper channels. Circumstances in each case preclude the supposition that the application of the cauterium acts through mere mental impression; the intra-laryngeal Faradization and cauterization of the pharyngeal follicle, as previously carried out in these cases, being equally impressive and, to the mind of the patient, more in harmony with the object in view, than treatment directed to the nose. Nor would one anticipate the same results from cauterization at random elsewhere on the body, for it is demonstrated that a special reflex-relationship exists between the sensory filaments of the nares and the motor-nerves of the larynx.—*Medical News*, February 22, 1890.

## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

**TREATMENT OF EPIDIDYMITIS.**—Langlebert has successfully used the following in the treatment of the above. The scrotum is covered by a thick layer of cotton, over which is placed a sheet of rubber tissue. This is held in place by a snugly fitting suspensory. The good results following this plan of treatment is explained by the writer to be due to the constant heat and profuse local sweating caused by the dressing, together with the fact that the part is immobilized and moderate compression secured.—*Annal. des Malad. des Org. Genito-Urin.*, 1889, No. 4.

**TREATMENT OF GONORRHOËAL ORCHITIS.**—Debeut has successfully used applications consisting of a 1 per cent. solution of nitrate of silver applied to the scrotum in the above trouble, curing his cases in from four to six days.—*Annal. des Malad. des Org. Genito-Urin.*

**TREPHINING FOR HÆMORRHAGE IN THE CRANIUM.**—Deaver, while admitting that a great deal has been done in brain surgery during the past two years, thinks the resulting benefit has, in the majority of cases, proven to be but temporary. This is largely due to the fact that the diseases are of such a nature as to preclude radical cure, i.e., tumors, which are most frequently sarcomatous, tubercular, or syphilitic, their removal, therefore, giving but temporary relief. These operations have accomplished most in demonstrating the amount of manipulation the brain will permit, providing that it is done by skilled hands and under every antiseptic precaution.

Trephining for intra-cranial hæmorrhage, particularly of the extra-dural variety, if done early, is in every sense a life-saving agent, practical as well as permanent in its results in the greater number of cases. There are four varieties of intra-cranial hæmorrhage. 1. Where the blood escapes or finds its way between the inner wall of the cranium and the dura mater. 2. Where it is in the sub-dural space. 3. Into the sub-arachnoid space and into the meshes of the pia mater. 4. Where it escapes into the substance of the brain, or into the ventricles. In the first variety the hæmorrhage is due, as Mr. Jacobson has shown, to a laceration of the branches of the middle meningeal artery, although not infrequently the artery itself is torn at the point where it crosses the anterior inferior angle of the parietal bone. The reasons for this are: 1. The bone at the site of the groove for the artery is very thin. 2. The vessel is frequently buried in the bone, so that fracture without laceration of the artery is scarcely possible. 3. The skull at this point is peculiarly apt to be broken. The artery may also be ruptured by force, which causes a detachment of the dura mater, but which is not sufficient to produce a frac-

ture. Next to this vessel the most frequent source of extra-dural bleeding is the lateral sinus. Owing to the intimate relations of the dura mater to the base of the skull, hæmorrhage in this situation is hardly possible. The attachments of the dura over the vault of the cranium are comparatively loose, except along the lines of the sutures, so that, as Bell has shown, it may be separated by the vibration caused from a blow. Tillaux, furthermore, has demonstrated that the adhesions between the dura and the bone are especially weak in the temporal fossa, the most common site of meningeal hæmorrhage. The following points are to be observed in the diagnosis of extra-dural hæmorrhage: The mental condition may be normal, or there may be cerebral irritation, complete or incomplete unconsciousness, or coma. Pupils may be normal; one or both may be dilated and show no response, or one may be greatly dilated and the other normal. Hutchinson has pointed out that in cases where the dilated pupil corresponds to the injured side it is due to the pressure of a clot extending down to the base of the skull on the cavernous sinus, causing fullness of the vessels. It may also be accounted for by pressure of the clot on the oculo-motor nerve. Respiration may be stertorous or Cheyne-Stokes in character. The pulse may be changed but little, depending much on the severity of the concussion; rapid and feeble, or if there is compression, slow and full. There may exist hemiplegia, monoplegia, paralysis, convulsions, twitching or spastic rigidity in various degree. The scalp may be contused and boggy from the injury, and the latter also by leakage from the cranium through a fissure. The following stages are usually presented by a typical case of extra-dural hæmorrhage: 1. Unconsciousness, complete or incomplete, due to concussion or shock caused by the injury. 2. Consciousness or lucidity. This stage may last from a few minutes to several hours. The following rules call for trephining in this class of cases: 1. Simple or compound depressed fractures, with or without symptoms of compression. 2. Punctured or incised fractures, fractures of the orbital plate of the frontal bone, punctures of the cribriform plate of the ethmoid. In the last mentioned the author applies the trephine to the roof of the orbit at the inner angle, this being the most dependent portion of the anterior cerebral fossa. 3. Foreign bodies in the brain. 4. Impacted fractures in gunshot wounds. 5. In contusions simulating depressed fractures the author exposes the skull, and if a depressed fracture be found or bleeding through a fissure, he trephines.—*Medical News*, February 15, 1890.

**FRACTURE OF THE PATELLA.**—Newell recommends a method practiced by Beach at the Massachusetts General Hospital for the treatment of patellar fractures. It is more simple and more easily applied than most others, and gives very good results. It consists of a ham splint, well padded, and two coaptation splints. The leg is fully extended; the ham splint reaches from the buttock to the lower third of the leg; the coaptation splints are placed on either side and held in place by buckle straps: these should pass over the quadriceps muscle; a roller bandage is applied over this to hold the fragments quiet. To relax the rectus femoris the limb should be elevated; this is done best by placing pillows under the leg and tying them to the limb, or, if necessary, to the bed by strips of a roller. After this is worn four or five weeks in bed, the patient may be allowed to get up, when this same apparatus can be used. The author mentions a case treated by this method that was able to walk well without a dressing at the end of nine weeks. It is advisable not to attempt motion at the knee too rapidly and to postpone its complete use even as long as a year.—*Medical Record*, March 15, 1890.

**FLAT FOOT AND INGROWING TOE-NAIL.**—Gibney reports one case from his own practice, and two from that of Abbé, in which a painful flat foot appeared to be dependent on an ingrowing toe-nail, and was cured by removal of the latter. Case 1. (Gibney) Pain in the sole, supposed to be rheumatic, with tenderness of the scaphoid. A proper shoe, massage and Faradism failed, but excision of the ingrowing nail, and resulting granulations, cured the patient. Case 2. (Abbé) Painful flat foot, unrelieved by a built-up shoe sole, massage, etc.; relieved at once by excision of an ingrowing nail, which had not, however, produced inflammation or granulations. Subsequent removal of the tender cicatrix resulted in a complete cure. Case 3. (Abbé) Flat foot of several years' standing; painful for a few months. Removal of a well-developed ingrowing toe-nail relieved the pain. Patient lost sight of.—*Annals of Surgery*, January, 1890.

**THE OPERATIVE TREATMENT OF PROSTATIC HYPERTROPHY.**—Kümmell recognizes three forms of hypertrophied prostate: (1) A symmetrical or asymmetrical

hypertrophy of the lateral lobes without any changes in the middle lobe. (2) A hypertrophy in which all three lobes are equally involved. (3) An enlargement of the third lobe. According to the author these varieties differ anatomically. The pyriform hypertrophy of the middle lobe is usually of a fibro-myomatous nature, whereas the hypertrophy of the lateral lobes is more often of an adenomatous character. Besides the ordinary methods of examination for prostatic hypertrophy the author especially recommends Leiter's cystoscope as modified by himself. Regarding the indications for operative interference, the first and foremost is sudden retention where the introduction of a catheter is not possible. In these cases supra-pubic puncture is advised, but this procedure is contra-indicated when kidney trouble or any morbid state of the muscular coats of the bladder exists. In other less urgent cases epicystotomy should be practiced, as by this method the prostate can readily be removed, and at the same time the mucous membrane of the bladder treated. After having opened and thoroughly irrigated the bladder, the hypertrophied portion is grasped with a pair of long forceps and strongly pulled up, when a wedge-shaped piece is removed near the urethral orifice by means of the thermo- or galvanocautery. In partial hypertrophy the part is merely cauterized. The prostatic urethra is then thoroughly dilated, the bladder carefully stitched and drained by a catheter *à femore* for about two weeks. After healing of the wound, attempts are made to develop the muscular power of the bladder by means of strychnia, cold irrigations and electricity. In three cases treated by this method, two recovered fully, and the third, up to the time of writing, was unable to completely empty the bladder, which the author attributes to the short duration of the after-treatment.—*Deutsche Medicinische Wochenschrift*, No. 10, 1889.

**DEATH FOLLOWING INTERNAL URETHROTOMY.**—At a meeting of the Medico-Chirurgical Society of Montreal, Dr. Bell reported a case of death following the above operation. The patient was admitted to the hospital with retention of urine, and was operated upon the next day, after which there was a sudden rise of temperature, suppression of urine, coma and death. The kidneys were found to be the seat of tubercular disease.—*New York Medical Journal*, March 8, 1890.

**THE FIRST THERAPEUTICAL MEASURE IN INTRACRANIAL HÆMORRHAGE.**—Heidenheim reports the case of a young man who was struck on the head during a fight; he fell down but got up and walked home, a distance of several miles, undressed and went to bed. His father, sleeping in the same bed, heard him moaning, got up to get him some water, but on his return found him unconscious, and he died in half an hour. An autopsy showed fractured skull and hæmorrhage between skull and *dura mater*. After citing some similar cases, Heidenheim says the rule may be laid down that after the appearance of a *mild attack of apoplexy the patient ought to be kept for many hours in a sitting position* in a comfortable chair, just as long as the state of the patient allows it. Ice on the head, a derivating hot foot-bath, leeches, and a rapidly acting purgative may often prevent a secondary severe hæmorrhage. Wrapping the lower extremities in Esmarch's bandages ought not to be neglected in similar cases.—*Berliner Klin. Wochenscher.*, 6, 1890.

**HYPODERMIC INJECTIONS OF CARBOLIC ACID IN TETANUS.**—A boy, of fifteen years, tore and contused his skin between the fourth and fifth toe, and a day or two afterwards tetanus set in all over his body, with trismus, opisthotonos, and extensive tension of the abdominal muscles. Hot baths, large doses of chloral failed, and on the fourth day Pauline began his injections with 1 per cent. carbolic acid, which were made every third hour, eight in twenty-four hours. Already, on the second day, the temperature (over 40°) dropped, and the spasms diminished in duration and intensity. With the continuing improvement the number of injections were diminished, and on the twenty-seventh day of treatment the patient could be considered cured. Baccelli, of Rome, treated a very grave case by the same method, and also saved his patient. The injections must be kept up till every trace of a spasm has disappeared.—*Wien. Med. Presse*, 7, 1890.

**HOT WATER FOR THE ARREST OF HÆMORRHAGE AFTER THE EXTRACTION OF TEETH.**—Dr. Julius Scheff stops the most obstinate bleeding from the alveolus after the extraction of teeth, even in hæmophilic patients, by dropping hot water into the cavity. The water must be as hot as can be borne, and the syringe must be so constructed that the hot water can be discharged in drops.—*Deutsche Med. Zeitung*, 22, 1890.

# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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CONDUCTED BY

CHARLES MOHR, M.D., AND EDWARD R. SNADER, M.D.,

WITH THE COLLABORATION OF

S. LILIENTHAL, M.D.,

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**A VERIFICATION OF A THUJA SYMPTOM.**—Dr. Edward Balch, in the *March Homœopathic Physician*, relates a case in which he was able to cure the symptom found under thuja, "Sweat on uncovered parts." One dose of thuja 30 removed the symptom.

**NUX VOMICA AND SEPIA IN "VERNAL CATARRH."**—"Vernal catarrh" is a conjunctivitis which comes on in the spring as warm weather begins, disappearing during a cold spell. It is rarely benefited and usually aggravated by any local application, and I succeed best with nux or sepia high.—Dr. Norton, *Chironian*, March.

**FERRUM PHOSPHORICUM IN CHOLERA INFANTUM.**—Ferrum phosphoricum is called for when the discharges from the bowels are frequent; the child becomes greatly reduced early in the course of the disease: there is stupor, with red face, dilated pupils, rolling of the head, and soft, full, flowing pulse. Farrington relates a case with these symptoms (in which belladonna and sulphur were each given in turn, but failed) that was quickly relieved by ferrum phosphoricum.—*Journal of Obstetrics*, March.

**SABADILLA IN HELMINTHIASIS.**—In children affected by worm symptoms sabadilla may be used when there is nausea and vomiting associated with a peculiar colic, as though the bowels were being whirled around like a wheel.—*Journal of Obstetrics*, March.

**VERATRUM ALBUM IN CONSTIPATION.**—A neglected drug in constipation is veratrum album. Inveterate, torpid cases, with the key-note of a little cold sweat on the hands or forehead, when straining at stool.—Dr. Moffat, *Chironian*, March.

**CONSTIPATION DURING PREGNANCY.**—Mrs. A., eighteen years old, light hair and blue eyes; primipara; has had constipation ever since she became enceinte. I had given her several remedies with no relief whatever. The fore part, or the first of the stools, is hard; the after, or last part, loose or diarrhetic. Itching, burning, and redness of the hands and feet. She says she can tell when she is going to be constipated, as her hands and feet itch and burn so, worse at night. She can scarcely sleep. *Agaricus muscarius* cm., one dose, made her better for two weeks. One dose more cured.—Dr. G. W. Sherbino, *Homœopathic Physician*, March.

**OLEANDER IN NURSING WOMEN.**—In studying the action of oleander on the abdominal organs we find emptiness and goneness in the pit of the stomach, even after eating, relieved by taking brandy. This symptom is an indication for oleander, in very weak women who have infants at the breast. Immediately after nursing the patient is seized with tremor, and is so weak that she is scarcely able to walk across the room.—*Journal of Obstetrics*, March.

**OPIUM IN PUERPERAL CASES.**—Besides the use of opium to relieve the retention of urine after parturition, attention has also been called to its curative effect in

children when, from fright of the wet nurse, the infant has retention of urine. As a remedy for affections in women, resulting from fright, opium has further seemed indicated in puerperal fever, where there is over-excitement of all the senses; even distant sounds annoy the patient; the discharge from the uterus is very fetid; the case approaches a condition of stupor.—*Journal of Obstetrics*, March.

**BOVISTA IN UTERINE TROUBLES.**—In uterine congestion, with uterine hæmorrhage, particularly when there is a flow of blood between the periods from any little over-exertion, bovista has been found very useful. The menstrual flow of bovista is characterized by occurring only at night or early in the morning.—*Journal of Obstetrics*, March:

**COCULUS, PULSATILLA, AND CHAMOMILLA IN MENSTRUAL COLIC.**—Farrington described a little group of remedies for menstrual colic, among which cocculus, pulsatilla, and chamomilla stand out very prominently. Under cocculus, the colic is as if there were sharp stones rubbing against each other in the abdomen. There is, very often, with this colic excessive distension of the abdomen from flatus. The colic is especially liable to come on at night and awaken the patient. It is relieved by belching, and returns again from the re-accumulation of flatus. Chamomilla also has cutting colic in the abdomen, with dark menstrual flow like cocculus, but is characterized by the peculiar irritability of the patient. Pulsatilla, likewise, has scanty and dark menstrual flow, with griping pains doubling the patient up, but is distinctive in its relief from cool air, and in the mild and tearful disposition of the woman to whom it is particularly adapted.—*Journal of Obstetrics*, March.

**XANTHOXYLUM IN HYSTERICAL DYSMENORRHOEA.**—Dr. D. N. Ray reports the cure with xanthoxylum of an exceedingly painful dysmenorrhœa occurring in a sixteen-year old hysterical patient.—*Journal of Obstetrics*, March.

**HAMAMELIS IN ABDOMINAL CONGESTION.**—It has been told us that hamamelis has often been used in pregnancy when varicose veins appeared over the abdomen, and when the patient could not make any motion without feeling a bruised, sore feeling. This characteristic of hamamelis, the great soreness of the part, is not the bruised feeling of arnica, nor the sensitive soreness of lachesia, nor the stinging soreness of apis. It is pointed out to us by Farrington as the sore feeling which belongs to venous congestion. The abdominal soreness of bryonia, belladonna, and of rhus toxicodendron, is distinguished from that of hamamelis by the individual characteristics which mark the uterine symptoms of each of these drugs.—*Journal of Obstetrics*, March.

**SABINA IN ABORTION.**—Sabina is indicated, especially in impending abortion about the third month, by a pain which commences in the small of the back and goes around and through the pubes, and by pains which run from the sacrum to the pubes. With these pains there is a flow of bright red, clotted blood, increased by every motion.—*Journal of Obstetrics*, March.

**STAPHYSAGRIA IN PROLAPSUS UTERI.**—Staphysagria is sometimes indicated in prolapsus uteri, in states where the prolapsus is associated with a flabby condition of the abdomen. The whole abdomen is so relaxed, contents and parietes, that there is a sensation as if everything would drop out. The leucorrhœa accompanying this condition is yellow and excoriating. All this is the result of repeated pelvic congestions from allowing the mind to dwell on sexual subjects.—*Journal of Obstetrics*, March.

**SULPHUR IN LEUCORRHOEA.**—An unmarried lady of twenty-eight suffered from leucorrhœa for eight or nine years. During these years she had had frequent prescriptions for vaginal washes, which did no good. She now uses a little castile soap in water once per day. Being a teacher, she stands much on her feet. The flow is profuse only during the day; must wear a napkin; the color is a whitish yellow; causes an intense itching and burning of the external parts. Has cold, sweaty feet; menstruation rather painful. She received calcarea 30, the only effect of which was to give her painless menstruation. This was followed by calcarea 200, first day four doses, then one dose a day. She improved only for the first two or three days. Then she received calcarea 200 in water, four doses, followed by placebo. Improvement was not perceptible. Now learned that she was troubled with heat of the palms of the hands at night; could not endure to have them under cover; if she

went to sleep with them covered up, in her sleep she would throw off the covering. Calcareo had been tried now for a month with but little amelioration. *Sulphur* 30, four doses in one day, was all the medicine taken for another month, with most gratifying results. As she then removed from this locality, she took with her sulphur 200, to be taken only when necessary. Have since learned from her friends that she blessed the day when she tried the "little pills."—Dr. M. F. Grove, in the *California Homoeopath*, February.

**SILICA IN MAMMARY FISTULA**—A young woman of twenty-four years of age, otherwise healthy, and without any disposition to sickness, was, fifteen months ago, delivered of her first child. In confinement she contracted mastitis, which turned into suppuration. The abscess was lanced by her physician and emptied, but the opening would not close in spite of all surgical and external means applied, and a thin ichorous fluid continued to form, so that the presence of a fistula could not be doubted. She received silica 30, a powder every other evening, and, after fourteen days, the opening was closed and the fistula healed, and remained so.—*Homoeopathic Recorder*, January.

**CALCAREA CARBONICA AND SILICA IN CARIES.**—Meta K., aged nine and a half years, came under treatment after she had been under allopathic treatment for over a year. The anæmic-looking child, of delicate constitution, suffered since her fourth year from rachitic appearances, eruptions and swellings of the glands. These disappeared in the course of time, with the exception of two carious ulcers on the sternum and a large swelling of the joint-ends of the upper part of the thigh bone. In consequence of this the lower part of the thigh bone was in an infected position and the knee-joint was almost ankylosed, so that the child could only creep, and had to be carried. There were no pains present. The suppuration of the carious bone swelling was as usual. The mark remaining from a previous bone swelling was yet deep, which is considered a sign of the continuance of the carious processes. There were no essential or characteristic symptoms present, except a certain want of appetite. The patient was given, first of all, *calcareo carbonica* 30, six globules morning and evening, then one daily, then every other evening, and so forth, with longer intermissions, for four months. After an intermission of one month we changed to silica 30, a few pellets every evening. The result is that the bone swellings are entirely cured and the existing marks have become flat, and that the raised joint-ends have become so diminished as to make the knee-joints again movable, and the lower leg so straight that she can step already on one-half of the sole of her foot. The child thereby looks blooming, is cheerful, and develops a healthy appetite. We hope to procure for the diseased extremity at least the appropriate normal length by using a proper extension machine.—*Allgemeine Hom. Zeitung* (*Homoeopathic Recorder*), January.

**CALCAREA FLUORICA IN INDURATIONS.**—Dr. G. P. Hale, in the February *Medical Advance*, reports the following case: Charles D. — had been under allopathic treatment for two weeks for typhlitis, and when called I found him very much reduced, suffering extreme pain. Palpation discovered a tumor extending from the cæcum to the inferior border of the liver, hard from induration and very sensitive. I found him lying upon the right side with the leg fixed upon the abdomen to relax the abdominal muscles. This position mitigated the severity of the pain. The indicated remedies were given for the acute symptoms, among which *rhus toxicodendron* was the most important, but the absorption of the induration threatened to be a stumbling block to recovery, and an old allopathic physician declared that an abscess would result; but under *calcareo fluorica* 3x, a small powder dry upon the tongue every two hours, the induration was rapidly absorbed, and a speedy recovery of an almost hopeless case was the result.

**THUJA IN IRRITABLE ULCER OF THE ANUS.**—Dr. G. W. Sherbino, in the March *Homoeopathic Physician*, reports the cure of an "irritable ulcer of the anus" with one dose of *thuja* 1m, after the failure of surgical procedures. Symptoms: The stools were hot as boiled lead passing through the rectum; pain after stool, lasting for many hours, so that he was in great pain from contraction of the anus; pain worse from motion, even moving his feet, and yet he got so very restless that he must move, and he got no relief from it whatever.

**THERAPEUTICS OF EPISTAXIS.**—Dr. Helmuth, in the February *Chironian*, gives the following medicines as of service in epistaxis:

**Crocus.**—Especially if the blood is thick and dark; useful, not only for the acute attack, in which case it is given every fifteen minutes, but also as a constitutional remedy, to prevent future attacks.

**Carbo Vegetabilis.**—Indicated in old people, who are more or less prostrated, whose blood is too thin. Has been known to stop hemorrhages even when plugging failed.

**Belladonna.**—When the face is flushed and full; throbbing pulse, bright-red blood.

**Erigeron.**—Cures many cases when the blood is thin and from both nostrils.

**Hamamelis.**—Particularly in hæmorrhoidal patients, when hæmorrhages are thin and venous.

**Arsenicum** is especially good when hæmorrhage has lasted a long time, the patient becoming prostrated, restless; great paleness; characteristic thirst; even life threatened.

**China.**—Especially good for repeated hæmorrhages, which produce anæmia, particularly when the blood is bright and clear, and the patient is a miasmatic or overdosed quinine subject.

**BARYTA IN MASTURBATION.**—"The habit of masturbation is a disease which no healthy boy will contract. Where boys develop imperfectly at the age of puberty, and acquire this habit, baryta is one of the remedies likely to be indicated."—Dr. Allen, *Chironian*, January.

**REMEDIES FOR HEADACHES IN EYE STRAIN.**—"In headaches from straining the eyes, remember natrum muriaticum, in throbbing in the forehead; cinchona for throbbing in the temples; calcaria phosphorica in the vertex: onosmodium across the occiput."—Dr. Allen, *Chironian*, January.

**BARYTA.**—"I have observed that baryta is especially active on the glands of the posterior cervical triangle, behind the sterno-mastoid and on the back of the neck."—Dr. Allen, *Chironian*, January.

**CAUSTICUM.**—"Stiffness and cracking of the articulation of the lower jaw, a rheumatic condition without fever, is entirely relieved by causticum."—Dr. Allen, *Chironian*, January.

**GUAIACUM** is very like rhus, follows rhus well, and will often relieve when rhus seems indicated and fails.—Dr. Moffat, *Chironian*, January.

**LITHIUM CARBONICUM IN ARTHRITIS.**—Dr. W. M. Fœlet cured with lithium carbonicum a case of subacute rheumatoid arthritis affecting the first and second joints of the index and middle fingers of each hand.—*Medical Advance*, March.

**DOSAGE OF PHOSPHORIC ACID.**—In giving phosphoric acid in physiological doses, continue it for a couple of weeks, then stop for a week, and go on again. You thus avoid overloading the system and guard against the secondary depressant effect.—Dr. Moffat, *Chironian*, March.

**NUX MOSCHATA IN AN "HEPATIC" CASE.**—Dr. M. F. Grove in the February *California Homœopath*, reports a peculiar case, of thirty years' standing, that had resisted all kinds of treatment. Rev. P—, aged about 40, had had attacks of excruciating pain since boyhood, but in latter years attacks came on every three weeks, and later every other day. Symptoms: An aching pain comes in the right hypochondrium, with sleepiness and restlessness. He becomes so drowsy that he feels he could sleep under any circumstances, except for the presence of the pain, and this must be quite severe to keep him awake. After this goes on from one to three hours, a swelling comes in the region of the gall-bladder, which becomes quite large and sensitive. This is then felt to be the seat of the aching pain. Hot applications, doubling up, and one-half ounce alcohol in water, help the pain and give him some relief. This suffering lasts from a few to twenty hours. The stools at this time are of a muddy, clayish color; thirsty all the time, but aggravated by drinking cold water. He suffers continually from a deficiency of saliva, and seldom expectorates even with a chew of tobacco in his mouth. There is noticed a puffy, baggy condition below the eyes. The case has been diagnosed by previously attending physicians as gall-stone colic and hepatic congestion. *Nux Moschata* 6 was given four times a day for two or three weeks, and was then given less frequently. The patient had but one slight attack after the medicine was administered



**TREATMENT OF HABITUAL DRUNKENNESS.**—Gallavardin, of Lyons, in his work *Alcoholism et Criminalité, Traitement Médical de L'ivrognerie et de L'ivresse*, shows up the evil habit of alcoholism, and then advises in relation to treatment to consider principally the mental symptoms, and in chronic diseases the single dose which often suffices for several months, and thus permanent cures can be effected. He recommends:

**Nux Vomica:** Tendency to anger; forced by worry and anxiety to benumb the mental troubles; spitting. When sober, kind and retiring; when drunk, quarrelsome or crying. Easily jealous and envious; suicide by drowning, or death by revolver and knife. Tendency to melancholy; increased or diminished sexual nism. Small doses of liquors cause drunkenness. Desire for red or white wines, beer, absinthe or rum; from doing nothing; from neurasthenia, women often want stimulants during or after pregnancy; lascivious thoughts and acts; does not care for medical advice; often longs to steal, and cunning; tendency to constipation, vomiting and rumination from difficult digestion; great smoker; gambler; spendthrift to others, but avaricious in the family; is never satisfied at home, but roams about with strangers.

**Lachesis:** Disagreeable, quarrelsome people; vindictive, malicious, just as leave kill somebody, but no tendency to suicide, except to be crushed by a car or wagon. Talkative during drunkenness; tell to others all their thoughts and how to execute them, which they would carefully guard when sober. Do not care about anybody. Smoker. Sometimes wasteful and squandering, at other times avaricious; always careless; desire for absinthe.

**Causticum:** Stubborn, quarrelsome or touchy, and easily crying during and after the spree; sexually excited before and during it (very characteristic of causticum); desire for brandy and rum. In persons who lost very dear friends. Adults as careless as children. Takes no interest in anybody. Smoker. Inclined to steal, as he cannot keep his hands off. Young women who want to get married. Very wasteful.

**Sulphur:** Herpetic and hæmorrhoidal constitution; is slow at work and when walking; likes to sleep late, but does not feel refreshed by it; muscles relaxed and flabby; tries to get drunk when alone; has neither will-power nor a sense of his duties; desire for beer and wine. Mild when sober, uncouth when drunk. Talks to everybody what he would keep to himself, or does actions which he would never do when sober; careless in mind and body; inclined to obesity; lies and steals; envious; somewhat dissolute; gambler and smoker.

**Calcareæ carb:** Fat and lazy, hence not obliging to others, and causeless apathy to some persons; lies and steals; brainfog from mental overwork. Envious, hateful, revengeful, somewhat dissolute, sometimes gambler. Wasteful, and at other times avaricious; will-power nearly abolished; has not the moral courage to refuse a glass of wine.

**Hepar:** No heart, constantly dissatisfied, hot-headed and could kill anybody in his rage; criminal tendency; cannot perform any mental labor without his glass of wine.

**Arsenicum:** Wicked, revengeful without charitableness, jealous, inclined to commit crime, suicidal tendency to hang, to drown, to poison or stab himself. Constant desire to drink, even if it is only water. Tendency to vomit and especially to diarrhoea; loves to persecute others.

**Mercurius vivus:** Discontent with himself, with others, with everything. Teeth easily become carious, gums swell up, ptialism, neuralgia, diarrhoea and dysentery, helminthiasis; great gambler, spendthrift or avaricious; spend everything as quick as they earn it; unbearable behavior; suffering from diseases which can be palliated.

**Petroleum:** Drunkard without any will power; cannot refuse liquors, though they vomit as soon as they have the least too much. Garrulous during their spree.

**Opium:** Whiskeyists, who drown their debasement in liquor. Easily moved to tears. Very funny but dull, and during their inebriety, sleeping. They are funny from wine, but drowsy and sleepy from beer, cider and whiskey.

**Staphisagria:** Drunkards, who excel in *Baccho et Venere*, and who try to strengthen their broken-down constitutions by liquors, especially sweet ones. Ill-humored and downcast before, during and after their drunkenness; hypochondria with delusions of persecutions. Old bachelors or married men given to adultery; Onanists; smokers; jealousy.

**Conium mac:** He drinks to brace up; full of envy; cold and icy manners; has

to indulge in everything he wants; fails to take interest in anything; mental capacity limited. Adults down-hearted like children; weakness of spine, with tendency to paraplegia.

*Pulsatilla*: Drinks to strengthen his stomach, as digestion is poor. During intoxication, down-hearted, with desire for cider. Chlorotic girls and women who indulge on account of their debility; fond of candies and sweets; jealous, envious and malicious. Spendthrift in order to show off. Bashful even to cowardice.

*Magnesia carb.*—Prefers sweets and fine liquors; irritable, downhearted, talkative or silent, face deep-red; insomnia at night, sleep in daytime; garrulous when drunk.

Gallavardin prescribes the drug in the 200th potency, a dose every two, three, four, six, seven weeks, given without the knowledge of the patient.

During the intoxication he prefers the following remedies in the 3d, 6th, 11th or 30th potency, 6 to 8 pellets in half a glass of water, a teaspoonful every five, ten, fifteen, twenty minutes. In the *convulsive form* of intoxication with convulsions of extremities, trunk and head: *Nux vom.*, bell. *Jealousy*: *Nux vom.*, lachesis, *pulsatilla*, *staphisagria*, *hyoscyamus*. *Fighting mood*: *Nux vom.*, *hepar*, *veratrum hyoscyamus*. *Destructive mood*: Bell., *veratrum*. *Killing mood*: Bell., *hepar*, *hyoscyamus*. *Suicidal mood*, by poison, dagger, hanging or being crushed: *Arsenicum*. By dagger, pistol or drowning: *Nux vom.* By poison or throwing himself down from a height: Bell. *Full of fun and mirth*: *Opium*, coffee. *Playing the actor*: *Stram.*, bell. *Clear-minded*: *Calcareas*, sulphur. *Dull-minded*: *Opium*, *stramonium*. *Sleepy or sleeping*: *Opium*, bell. *Insomnia*: *Nux vom.*, coffee. *Garrulous*: *Lachesis*, *causticum*, *hepar*, *petroleum*, *magnesia carb.* *Screaming*: *Stramonium*, *hyoscyamus*, *ignatia*, *causticum*. *Scolding*: *Nux vom.*, *hepar*, *petroleum*. *Crossness* before, during and after the spree: *Hydrastis*, *nux vom.*, *caust.*, *lachesis*. *Desire to go naked*: *Hyoscyamus*. *Excited sexuality*: *Nux vom.*, china, phosphor., *cantharides*, and especially *causticum*.

It is far better the patient does not know that he is treated for his vice. Drunkenness is a mental alienation with its obstinacy towards doctor and friends, and the drug shows the same effect when given in soup, wine, coffee or even in liquor.

There is an acquired and a hereditary drunkenness; the former yields more easily to treatment, the latter is often the bane of the descendants of drunken parents, especially when conceived during the bout. To prevent such dire consequences such children must be treated from their thirteenth to fifteenth years and longer with the following remedies in the order given and in the 200th potency: 1. Sulphur, forty days. 2. *Nux vom.*, forty days. 3. *Arsenicum*, forty days. 4. *Mercur. vivus*, forty days. 5. *Opium*, forty days. 6. *Lachesis*, forty days. 7. *Pulsatilla*, forty days. 8. *Petroleum*, sixty days. 9. *Conium*, sixty days. 10. *Causticum*, sixty days. 11. *Magnesia carb.*, sixty days. 12. *Staphisagria*, forty days. 13. *Calcareas carb.*, sixty days. Only the high potencies answer; low dilutions will fail. Children under thirteen years may be treated with the 30th potency and then the intervals can be shortened, as sulphur after twenty, petroleum after thirty days. Modification in the sequence may be necessary according to the individuality of the case, and the attending physician must be the judge. In relation to diet hardly any measures can be proposed, as the treatment must be carried on without the knowledge of the patient; still we might advise a diminution of animal food and must raise our voice against tobacco, as it increases the thirst. Fat meat, bacon, butter, cream, milk and vegetables diminish thirst and hunger. A habitual tippler cannot break up his evil habit at once, and it is questionable whether it is advisable, for alcohol increases the activity of the heart and removes an exhausted feeling. We know that soldiers after a long and tedious march are strengthened by a small portion of spirits, whereas when they take it before they set out, they become far earlier fatigued. Stanley reports, that alcoholic beverages in central Africa cause too often hepatic troubles; heat-fever, mental troubles, even inside of their tents, while, when taken before retiring in small doses they quiet the heart and produce sleep. Alienists often prescribe to their excited patients small doses of alcohol in the evening to make them sleep. It was an old fashion when the host presented a nightcap to his guests before retiring, and the use of alcohol in pernicious fevers and against the bites of poisonous animals is a mode of treatment recognized in all schools.

It is not an easy matter to treat habitual drunkenness; it takes patience and time.

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A REPORT OF CASES TREATED BY ABDOMINAL SECTION.

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IN this report I have aimed to furnish a concise history of twenty consecutive cases operated by abdominal section in my private hospital, or at the gynæcological clinics in the Hahnemann Hospital of Philadelphia.

It may be stated that, until within a period of six months, it was believed that the risk from the presence of a large class of students would not justify an operation of this character during the regular clinic hour, but by dividing the class into sections of from ten to fifteen to witness an operation, the risks have been somewhat diminished, and, with the assistance of willing and intelligent nurses who have been personally instructed, I can report all clinical cases as having recovered.

That special hospital facilities, and experienced nurses, are necessary for the successful treatment of patients requiring abdominal section, is too well known to need mention. If additional proof was required, I might point to the fact that from my total number of hospital cases only one death has occurred, if I may exclude patients found to be suffering from malignant disease at the time of the operation, whilst a much larger number operated on at their homes give a much greater percentage of mortality. This has been attained mainly on account of inadequate facilities, but it is also due to the fact that many of them were too much reduced in health to justify the risk of removal to an institution adapted to their requirements.

With regard to such patients, it has been a question for serious consideration, in every instance, whether or not they were beyond the pale of the surgeon's resources when his services have to be solicited. Yet, when every other means had failed, and an operation was eagerly desired, a fear of increasing an individual mortality rate has not deterred me from using the best surgical means at my disposal in the hope of affording relief.

Those desperate cases of long standing, for which so little can be done, have forced home the conviction that from diseased tubes and ovaries such serious mischief arises as to warrant their removal in the earliest stages of the affection, whenever other well-directed efforts fail to bring relief, and, whilst Tait's operation may be resorted to, at the present time, in too many instances, it has a wide range of application, the scope of which may be narrowed but will never be annulled. The efficacy of our system of treatment may be all that can be desired in the early stages of the affection, but when serious havoc has been wrought, and until we know from experience just where the obstacles become insurmountable by medicinal means, who shall draw the line that shall restrict the operation to its narrowest limits?

CASE 1 was about 47 years of age; the menses having ceased for nearly two years. She was unmarried; almost constantly bedridden from pelvic pain and functional disturbances of the rectum and bladder, due to the presence of two large-sized tumors situated on either side of the uterus, which, with this organ, seemed to fill the pelvis completely. A vaginal examination was extremely painful, and the passage of the finger into the rectum proved that it was encroached upon by a firm body which was quite immovable. One of the tumors, at the side of the uterus, seemed somewhat soft, and felt as if it contained a fluid within a thick capsule. At the time of the operation at my surgical rooms, both tumors were found to be fibro-myomas—one quite soft, the other more firm, and both intraligamentous. Considering the difficulties to be encountered in the effort to enucleate them from their beds in the broad-ligaments, and the fact that under favorable circumstances they might diminish in size at her time of life, the fingers were insinuated behind the tumors in the pelvis, and they were lifted to a more favorable position in front of the sacral promontory, and the abdominal incision closed. Recovery was uninterrupted; and since that time the tumors have diminished in size, the pelvic distress has never been of much consequence, so that she was able to spend the summer in Switzer-

land, and since her return last fall has had but little to complain of excepting the results of an attack of *la grippe* last winter.

Tait and others have called attention to the improvement which has often followed abdominal section without extraction, in such cases, and it has been difficult to account for it in many instances; perhaps, however, more is to be attributed to the influence the manipulation has upon their vascular supply than to anything else.

CASE 2 came under my care at the 6th month of a second pregnancy. A cystic tumor had been diagnosed by her physician immediately after her first parturition. This could now be outlined as a thin-walled cyst to the right of the enlarged uterus. Per-vaginum, the lower part of the cyst, could be felt back of the uterus, and the question of removal for fear of some interference with parturition was seriously considered. In arriving at a conclusion upon this subject, as well as during the subsequent operative treatment of the case, I availed myself of the counsel of Dr. C. M. Thomas, and it was decided to await developments before interfering, as the tumor did not seem to be seriously encroached upon by the pregnant uterus, and consequently there was no immediate danger of rupture.

Parturition was apparently normal, and no complications ensued during the lying-in period.

At first the cyst wall could be outlined only after considerable searching, as it seemed to be attenuated and but partially filled with fluid. After awhile it became more tense, and occupied a high position in the abdominal cavity. If it was ovarian in origin I decided that it had formed attachments during gestation which did not permit of its descent, and as it was growing, it was deemed best to remove it.

As soon as the abdomen was opened the cyst was found to be of renal origin, due to an occlusion of the ureter, from which dilatation of the pelvis of the kidney had ensued, followed by atrophy of all the remaining kidney structure as the accumulation increased.

By stripping off the peritoneal covering of the hydronephrotic cyst, the tumor was enucleated, and a stout silk ligature was passed around the renal vessels, which form a pedicle; after which the mass was cut away. An opening was next made in the flank, through which a drainage-tube was passed from the bottom of the peritoneal sack. The latter was closed at the top by means of interrupted sutures of catgut, and the abdominal walls brought together by silk-worm gut. No difficulty was experienced from the use of ether as

an anæsthetic in this case, as we might expect when the functional action of the kidneys is impaired.

There was everything in the mental status of the patient to promote her recovery; being very hopeful, trustful and obedient, she progressed finely. The highest temperature indicated by the thermometer was 103° F. on the twenty-second day, when a pocketing of pus about the drainage-tube called for dilatation and the introduction of a larger tube, after which more perfect drainage was effected until the sack was entirely closed.

The quantity of urine secreted from the remaining kidney, after food was admissible and moderate draughts of water partaken of, measured from fifteen to twenty ounces in the twenty-four hours.

I considered it fortunate in this case that the kidney structure on the diseased side had almost entirely disappeared from depression due to the accumulated urine within the sack before the operation, as the extra tax upon the remaining organ had been so gradually imposed, that there was no sudden call upon its resources at the time of the removal of the cyst.

Since the operation the patient has given birth to another child without serious complications from impairment of kidney action. At no time did she seem to suffer from uræmic toxæmia. One month before parturition she passed about thirty-five ounces of urine per diem, of a specific gravity of 1019. Total solids 48 + grams (normal between 60 and 70) = urea 21.29 grams (normal 30 to 35 grams), without albumen or casts.

Four months after parturition the specific gravity of the urine was 1033, and the quantity increased with the amount of urea almost normal. The patient's health has been very good ever since.

CASE 3 suffered from obstruction of the bowels, with vomiting and intense pain, due to an ovarian cyst of about two years' growth. She was anæmic, jaundiced and a sufferer from heart disease. After getting her into as favorable a condition as possible, she was operated on at my surgical rooms and the cyst found to be universally adherent. Before it could be enucleated, the heart's action became so weak that it was thought best to discontinue the efforts at extraction. After cleaning out the cyst as well as possible, a drainage-tube was introduced, the walls stitched to the abdominal incision, and the patient put to bed. The pulse was gradually re-established at the wrist, and in a few weeks she returned to her home in the centre of the State. After a time she began to show signs of septic infection, and died about two years from the time of the operation without

affording us another opportunity to attempt the enucleation of the tumor.

CASE 4 was unmarried and about 27 years of age. She suffered intensely from dysmenorrhœa and pelvic pains, from which she became a confirmed invalid. The uterus was enlarged and the lymphatic glands of the neck, axilla and also of the pelvis were swollen and very painful. It was decided to remove the ovaries to induce a cessation of the menses. Peritonitis developed soon after the operation and ended fatally on the seventh day.

CASE 5 was married, but sterile. The menses had been irregular and the abdomen enlarged from the development of an ovarian cyst for several months. At the operation two ovarian tumors were removed, after which recovery was speedily affected and perfect health restored.

CASE 6 was a married woman about 40 years of age and the mother of a large family of children. She had always been delicate and subject to profuse menses. Medicines and mechanical means had all been tried, with only temporary benefit. An enlargement of the right ovary manifested itself soon after a miscarriage, with profuse hæmorrhage, but diminished in size, as the process of involution was completed in the uterus, until it was about as large as a hen's egg, but very sensitive to touch or pressure. At the time of the operation the left ovary contained one blood-clot about the size of an English walnut, and another, somewhat smaller, covered over by a thin layer of ovarian tissue. In the right ovary there was a cavity which had evidently resulted from a similar hæmatoma of more remote origin that had undergone degenerative softening and partial absorption. Both ovaries, with their corresponding tubes, were removed. Recovery was prompt and menstruation has ceased entirely for over a year. The patient being relieved of her hæmorrhages has gained in strength as well as weight, and is able to look after the interests of her family as she has never done before.

Many illustrations might be given in this report of the efficacy of homœopathic medication after abdominal sections. One is noteworthy in this connection; as is mostly the case after an oöphorectomy, a slight discharge of blood occurred on the third day, like a menstrual flow, which was attended with intense backache and pelvic pain, frontal headache and depression of spirits. Puls. 30 was prescribed in water, and one dose sufficed to relieve her of her discomfort, so that she passed a quiet night and had no return of the symptoms afterward.

CASE 7 was a married lady about 48 years of age who had frequently suffered from attacks of pain in the abdomen due to impaction of *fæces*, associated with violent headache. An examination was made about seven years ago, at which time I detected an enlarged ovary and advised her to put herself under treatment. But this advice was not followed until the early part of last spring, when the abdomen began to enlarge rapidly and the tumor was surrounded by a quantity of ascitic fluid, which at times would entirely obscure its outlines. With the rapid increase in both the size of the tumor and the quantity of fluid in the abdomen the patient's sufferings became intense, and it was found necessary to bring her from the country in July and operate on her at my private hospital. When the incision was made a large quantity of ascitic fluid was liberated before the cyst could be seen. It was then emptied of its contents and removed. A drainage-tube was used, through which further accumulations of ascitic fluid could be evacuated. This dropsical fluid was obtained in large quantities from the tube at first, but it gradually decreased in quantity until it ceased entirely, and the tube was removed during the third week. The patient's health is now completely restored.

CASE 8 was a young unmarried lady who suffered from pelvic pain due to the development of a cyst of the broad ligament which would gravitate into the cul-de-sac of Douglas with its corresponding ovary and become more or less firmly impacted behind the uterus. The only support that afforded any relief was a soft rubber ring, which had to be readjusted every few weeks, or supplanted by cotton tampons, until the organs would again tolerate it. The removal of the tumor with the tubes and both ovaries, which latter bore evidences of cystic degeneration was effected at my private hospital in November. Recovery was uninterrupted except from an attack of enteralgia, with symptoms of obstruction of the bowels, which had to be relieved by means of forcible injections through a long tube, which was passed high up into the bowel. The patient now expresses herself as being free from pain and stronger than she has ever been. Her health seems to be perfect.

CASE 9 was a patient who had always suffered from violent dysmenorrhœa. She was unmarried, about twenty-three years of age, and incapacitated from doing anything by which she could earn a livelihood, by the recurrence of pains which set in a week before the flow; lasted continuously during the week of the flow, and remained to harass her for a week after the flow had ceased. She was



thin, pale and discouraged. Both ovaries with the tubes were removed in November, before a small class of students. After the operation great difficulty was experienced in getting the bowels to act, and for weeks care had to be used in the selection of food or the bowels would become clogged, and vomiting with severe pain ensued. Purgation was followed by paresis of the bowel and left her in a worse condition than before. With sulphur, alumina, bryonia and other remedies, this condition was improved, and three months after the operation she was perfectly well, and stronger and healthier-looking than ever before. There has been no menstruation, consequently no pain, and the bowels are much less constipated than formerly.

CASE 10 was admitted to the Hahnemann Hospital, with a diagnosis of ovarian cyst. Subsequently there were evidences of supuration, such as a recurrence of chills, followed by fever, burning in the tumor and tenderness, with redness of the skin over the seat of disease. When the abdomen was opened, a medium-sized ovarian cyst presented itself to view. It was readily removed, as there were but few adhesions. The patient's recovery was somewhat retarded by an attack of pleurisy, induced by leaving off an undervest at the time of the operation, which was not detected for several days afterward. After this, recovery was completed, without further complications. Bryonia, followed by sulphur, cured the pleurisy.

CASE 11 was a married woman, the mother of several children. Her case presented many of the symptoms of abdominal dropsy. She was brought before the class for an examination, and I was able to diagnose an abdominal tumor. Although there was dulness over the most dependent part of the abdomen, and sagging at the flanks in the dorsal position and a fluctuation thrill on combined percussion and palpation of the abdominal walls, I could detect the outlines of a mass within the abdominal cavity which indicated the presence of a tumor. At the time of the operation, the cavity of the abdomen was filled with a gelatiniform mass, without any distinct enveloping membrane. This mass had to be scooped out with the hand, and when it was removed, no trace of a tumor was left but the nutrient vessels which formed a stalk-like pedicle that could be traced to the pelvis. This was ligated near its point of origin and cut away. The patient recovered slowly, and is now in good health.

It is likely that the growth commenced in the organ of Rosenmüller, and that in its development it separated the folds of the broad

ligament, and carried the ovary with it into the abdominal cavity as was also the case with the bladder which became adherent to the anterior wall of the abdomen above the symphysis pubis. When the abdominal incision was made, and the peritoneum reached, it was found much thickened and had incorporated with it a fine structure which proved to be the bladder-wall. This was cut into, so that the finger passed directly into that viscus. In opening the abdomen above this point, I reached and cut through a mass which was adherent as closely to the peritoneum as the bladder was at a point lower down; this resembled ovarian tissue, and I believe it to have been carried upward by the growth from below and deposited against the anterior wall of the abdomen, to which it became firmly adherent, and as it received its nutrient supply from the seat of attachment, and was deprived of all nerve connection with the uterus, it was allowed to remain, for its dislodgement would have left a raw surface devoid of peritoneum as large as the palmar surface of a man's hand.

The incision into the bladder was treated by the introduction of interrupted catgut sutures to the mucous membrane first; then a continuous suture of prepared silk was used to approximate the muscular wall, after which the usual silk-worm gut sutures were used to close up the abdominal incision. A drainage-tube was introduced into the peritoneal cavity, and a catheter worn in the urethra to prevent the bladder from filling. The latter was removed in about five days, and no vesical symptoms were ever complained of. Through the drainage-tube a considerable amount of the jelly-like material was obtained for several days after the operation, showing how difficult it was to get all of this material away by irrigation during the operation. In this case the connective-tissue corpuscles seemed to have proliferated and formed embryonæ-like cells, which were completely transformed by colloid degeneration into a jelly-like mass entirely homogeneous throughout.

The early ovariectomists considered such a condition due to malignant disease, and in Case CXVII. of Atlee's work on ovarian tumors, we find a description of "a colloid tumor of the abdomen mistaken for ascites, and also for ovarian dropsy, tapped, removing a substance resembling calf's-feet jelly, and death five days after," which resembled the case under consideration in many particulars. Atlee says of his case that fluctuation was distinct, but gave the impression of a thick heavy fluid. When tapped, no fluid escaped, and, surprised at this, a female catheter was introduced through the canula,

and by moving it about he felt it break up a delicate network within, and detach some of the jelly-like substance. The patient died before an operation was performed, and from subsequent experience he looked upon this case as one of malignant colloid tumor of the abdomen, without any relation to the ovary. Whilst this form of tumor may originate from other than the ovarian site, its development in the manner indicated in this case should not be overlooked, for by the agglutination of the attenuated peritoneal surface with the abdominal peritoneum, its apparent seat of attachment may mislead the operator as to its origin.

CASE 12 was a colored woman from Virginia, about forty years of age, who suffered from a fibroid uterus and a cyst of the right broad ligament. At the operation the intestinal adhesions were found to be general, but after dissecting them away from the fibroid the pedicle of attachment with the body of the uterus was reached, the constricting wire of the écraseur made to circumscribe it, and it was removed. The way to the cyst of the broad ligament was now open, but as it had no pedicle, and was without a capsule that could be found, and adherent to the pelvic walls and intestines, it was tapped and drained with the hope of having the opposite walls become adherent, as is often the case with such tumors when they are tapped without an abdominal section.

With the écraseur constricting the stump, it was dressed extra-peritoneally with fresh dry Monsell's solution, and then iodoform and iodoform gauze as a protective, and allowed to slough away by tightening the constricting wire of the écraseur daily. The stump sloughed off in about ten days after the operation, leaving a large suppurating surface. A few days after this, whilst administering an enema, the nurse found the contents of the bowel passed through the wound, and a fistula was formed. Alongside of this fistula was another opening, which led into the broad ligament cyst, which was not entirely closed. The patient was allowed to remain in the hospital until she was ready for another abdominal section to close the intestinal fistula (see Case 19).

CASE 13 came from Belvidere, N. J., and complained of a great amount of ovarian distress and debility during the menstrual flow, from which she had become a confirmed invalid. The uterine appendages were removed by abdominal section, and she recovered without an unfavorable symptom. From her physician I have learned that she has less of the debility, having grown stouter, but is quite

nervous, a condition which is likely to remain until the symptoms of the premature menopause have subsided.

CASE 14 was under my care at the Hahnemann Hospital two years ago. At that time she was tapped, and a large quantity of clear, straw-colored fluid was drawn off from a cyst of the broad-ligament. This having refilled so as to cause her much discomfort I proposed to remove it by abdominal section, which she consented to. A speedy recovery was effected after the operation.

CASE 15 was a colored woman with a fibroid uterus and sterile. She suffered from pain and menorrhagia. The abdomen was opened, the ovaries removed and the upper parts of the broad-ligaments were ligated to cut off the vascular supply as much as possible. When she left the hospital the menstrual flow had not been abolished but was less profuse than before.

CASE 16 was a widow, aged 67 years, who had suffered a long time from a fibroid tumor of the uterus. I was summoned by her physician at Fox Chase to visit her, and found her subject to attacks of great pain and occasional metrorrhagia. She desired to come to my private hospital. Upon her admission I soon learned that the abdominal walls were infiltrated with cancerous tissue, and informed her that an operation for the removal of the tumor could not be curative. She assured me she would never leave the institution until some means were used to relieve her. I cut down through the hardened cancerous tissue on the front of the abdomen and reached the tumor; this had also undergone cancerous degeneration, and was removed with the entire uterus and ovaries. The pedicle was clamped and brought out through the abdominal incision, and dressed as the pedicle in case 12. She suffered no pain or inconvenience after the operation, but having no desire for food or apparent ability to digest it, nutrient enema failed to sustain life, and she died on the fourth day after the operation.

CASE 17 was a case of gonorrhœal Fallopian salpingitis and perioövaritis in a young unmarried woman, about 20 years of age. She had been attended as an out-patient by the clinical assistants in the dispensary, and when she was admitted to the hospital had a temperature of 104° F., with *la grippe* symptoms. When these subsided the old peritoneal inflammation caused her much distress, and, as menstruation was very painful, an abdominal section was resorted to. There was a considerable amount of plastic lymph, which agglutinated the pelvic organs together, but this was easily broken up except upon the left side, where there was a mass which

bound the intestines to the pelvic walls, and in which the ovary was lost. The entire ovary and the tubes were removed. Recovery was promptly effected, but when she last reported she was suffering from considerable pain at times in the left side of the pelvis. Perhaps I should have persisted in the effort to remove the other ovary, although at the risk of stripping the peritoneum off the intestine.

CASE 18 was an unmarried lady, 63 years of age, a patient of Dr. W. W. H. Neville. By the courtesy of Dr. Crosby, of Atlantic City, I examined the case several years ago, and found her suffering from a fibroid tumor of the uterus. As but little inconvenience was complained of at that time, and because her former physician, Dr. W. L. Atlee, had advised her never to consent to an operation, but little was said respecting this method of treatment. But whilst in the Catskill Mountains last summer her suffering became much more severe, so that vesical and rectal tenesmus was intense, and such loss of rest at night ensued as to seriously impair her health. At the request of Dr. Neville I saw her, and whilst she was relieved temporarily by medicines, I failed to see any prospect in the future for her that was at all encouraging without hysterectomy. She gladly accepted my proposition to attempt this operation, after all the difficulties and dangers were explained to her, and she was brought to my private hospital. The fibroid had softened and developed rapidly during the past few months, so that it would almost fluctuate. It grew from a broad base upon the posterior wall of the uterus, so that the uterus, tumor, and left Fallopian tube were removed together. The hand was next passed to the bottom of the pelvis, when another tumor was detected which had been overridden by the fibroid. This was tapped and found to be a dermoid cyst filled with hair, skin and bone, with a quantity of fatty matter.

Upon attempting its removal it was found to be adherent to the pelvic wall, but as the adhesions were friable it was torn away, when a ragged disintegrating surface was exposed to view, which showed too plainly the malignant degeneration which was going on. Bleeding was stopped by hot water after all shreddy masses were removed. The abdominal cavity was well washed out, a drainage-tube introduced to the site of the attachment of the dermoid cyst, the uterine stump dropped back into the pelvis, and the abdominal incision closed by silk-worm sutures.

The patient suffered but little from shock, and for some time she progressed very satisfactorily, except that very offensive discharges were obtained from the drainage-tube. In five weeks after the

operation she was moved from the bed to the lounge and back again, but one night I was summoned by the nurse, who informed me that she had had a convulsive attack followed by trismus. I etherized the patient, opened up the abdomen sufficient to introduce my finger, and washed out the peritoneal cavity thoroughly and drained it by turning her on to the side, but could find no trace of pus. Several medicines were prescribed, and enemata containing chloral hydrate were administered per rectum, but the patient succumbed in two days without any abatement of the lock-jaw. At the autopsy it was learned that the site of dermoid attachment had been hedged about by a wall of lymph, through which there was no opening save that for the drainage-tube, but within this closed sack the tissues were all disintegrated. A microscopic examination, made by Dr. E. W. Mercer, proved that the dermoid cyst had undergone cancerous degeneration.

CASE 19 was operated by abdominal section, in order to close an intestinal fistula resulting from a slough after a previous myotomy (Case 12). The opening was closed by Lembert sutures, the small cyst that was left in the broad ligament was drained and the tube left in the cavity. Alongside of this the intestinal fistula reformed in a few days, but gradually closed before the patient returned to her home in Virginia.

CASE 20 was a patient aged 67 years, who had always led an active life, but was never considered robust. She suffered from dysuria, attacks of diarrhoea and rectal tenesmus, with vomiting and indigestion. After having relieved many of these symptoms with medicines the abdomen began to swell, so that she was unable to either sit or lie with comfort from the fluid accumulation within. Her appetite became impaired and emaciation progressed rapidly, so that relief from the fluid accumulation in the abdomen seemed to be urgently demanded. Anteriorly the abdomen protruded like the segment of a cone. On the sides there was resonance upon percussion and dulness in the anterior part when in the dorsal decubitus. Being satisfied of the necessity for an evacuation of the abnormal accumulation, I decided to make an exploratory incision and be prepared to remove all that could conduce to the relief of the patient's sufferings. She was informed of my decision, and after some consideration reached the conclusion that she would go into my private hospital for treatment. The abdomen was opened by a small incision, and a quantity of clear ascitic fluid liberated. Through the opening the finger was introduced into a cavity bounded by inter-

tines fastened to the abdominal parietes laterally and posteriorly, and by a deposit of cancerous material which had also extended to the stomach and liver, producing a well-defined boundary for the ascitic fluid which had accumulated within. After the evacuation of the fluid the incision was closed and the patient put to bed. It was at least gratifying to those who knew of her great discomfort in sitting and lying before the operation to find her able to rest in the recumbent position. She gradually sank, and died eight days after the operation.

In connection with this case I would say that when it becomes necessary to evacuate fluids from the peritoneal cavity, I can see no reason why an exploratory incision made with proper antiseptic precautions should not supersede the blind introduction of a trocar and canula, which reveals nothing in doubtful cases and never acts curatively.

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## A NEW AND SCIENTIFIC MATERIA MEDICA BASED ON PURE PATHOGENESY.

BY THE MEDICAL INVESTIGATION CLUB OF BALTIMORE, MD.

### APIS MELLIFICA.—HISTORY.

ANIMAL substances used in homœopathic medicine may be divided into four groups, *i.e.*, *vertebrata*, *mollusca*, *radiata* and *articulata*; and it is in this last group that the drug now demanding attention is found. Of the seven subdivisions of the group, the *apis mellifica* or honey-bee belongs to the order of *hymenoptera*, and is closely allied to the *vespa* or wasp, and the *formica* or ant.

Messrs. Kirby and Spence, in their *Introduction to Entomology*, vol. i., published in 1815, hint at the medicinal value of insect poisons, which has been so fully borne out by later investigations. Speaking of the many kinds of insects made use of in past ages, and of the few now claiming a place in the "regular" *materia medica* of the day, they say :

"From having ascribed too much efficacy to insect remedies, we may now ascribe too little. Many insects emit very powerful odors, and some produce extraordinary effects on the human frame; and it is an idea not altogether to be rejected that they may concentrate into a smaller compass the properties and virtues of the plants upon which

they feed, and thus afford medicines more powerful in operation than the plants themselves. It is at least worth while to institute a set of experiments with this view."

Apis as a remedy is of especial interest to the homœopath, as the knowledge of its medicinal value has been solely developed in the homœopathic school, where alone it is given place as a medicine. Dr. Hughes says the remedy was suggested from Indian experience, it being there used in the form of a trituration for dropsies; Dr. Marcy, says: "The powder of dried honey-bees has long been known and used as a remedy in dropsies by the aborigines of our country; and Dr. Hering mentions an old Tennessee midwife having used bee-tea to cure strangury.

The first authentic record, however, of the application of the bee poison for therapeutic purposes was in 1835 by a veterinary surgeon named Branus, who used an alcoholic dilution of the virus to antidote wasp stings upon animals, and later prescribed it for boils and swellings. Soon after, we find it the active principle of a secret medicine, used locally for the treatment of various diseases. "This treatment was introduced by a German named Baunscheidt, in 1848, and consists of the introduction of a certain oil into the system through little punctures made by an instrument called the lebenswecker. For a time it was not known exactly what were the constituents of the oil of Baunscheidt; but it has recently been found to consist of apis mellifica virus mixed with pure olive oil," and the cures have been those in which apis would have been homœopathically indicated.

Dr. Humphrey, of Utica, N. Y., of "homœopathic specific" fame, was the first prover, in 1848, taking repeated doses of a tincture made by irritating bees in a bottle and pouring alcohol on them; and in 1850 he issued a pamphlet giving his experience. After his first proving, Dr. Humphrey proposed the drug for trial to the Central Homœopathic Society, of New York. Drs. Bishop and Meeger were appointed a committee to prove it with him, and the first experiments appeared in the form of serials under the title of "American Drug Provings."

The importance of the drug was at once recognized, and we find other provers soon taking up the work, Dr. C. W. Wolf, in Germany, and Drs. Marcy and Hering in this country being the most prominent. The former, an eminent practitioner of Berlin, was among the first to extensively introduce the new drug into his practice; and he published a small treatise upon apis, in 1858. At that time it was the epidemic remedy in Berlin for "fever and ague," and Dr. Wolf was



enthusiastic in his writings and endeavors to widen the range of the new remedy. Dr. L. Stern, of Poland, also introduced it with great success as a remedy for "chills."

Closely following upon these experiments came papers by Wm. Radde in Dr. Metcalf's *Homœopathic Proving*s, and also an English translation of Dr. Wolf's monograph on apis.

Florian Sirsch, a homœopathic physician at Schonberg, becoming interested in the numerous cures being made by apis internally, and having in mind the good effects of Baunscheidtism, prepared an apis oil for external application. The method of preparation was the same as recommended for the tincture, oil being used instead of alcohol. This he applied after first using the "lebenswecker," and he claims to have effected cures of cases which could not have been made by the internal use of apis.

Baunscheidtism seems to have had a number of followers, for we find mention of several physicians reporting success from its use, and apis had almost assumed the place of a polychrest among homœopathic remedies; but Dr. Goullon holds that "repeated unprejudiced experiments, such as have been made up to the present time (1876), induce us to assign to apis a position in the materia medica much more limited than that assigned to it by Dr. Wolf almost twenty years ago," and our researches (1883) support Dr. Goullon's opinion.

The apium virus is said to owe its properties to certain pungent salts contained therein. These may readily be seen if a drop of the poison be dried upon a slide and examined under a microscope, when they will appear as whitish, flaky crystals, very similar to the lachesis virus; and the active principle, as in most animal poisons, is soluble in alcohol. The statement of Dr. Hale (1876) that alcohol destroys the virus of animal poisons has, with few exceptions, been amply refuted by the experience of many physicians of both schools.

In many a preparation of apis for medicinal use, it should be remembered that only the females and neuters or workers are possessed of the poison. There are two preparations used in homœopathic practice, the one being a trituration of the entire, or abdominal portion of the bee, and is known as apis mellifica. The other is a tincture made from the poison itself, and is known as apium virus. Various modes of preparation have been advocated by as many different physicians, a few of the more rational of which are given.

The *British Pharmacopœia* recommends a trituration of the entire

dried bee, and also a tincture made by maceration of the hinder portion after killing the insect while in a state of excitement.

Our present *Pharmacopœia* directs "living bees to be introduced into a bottle, made angry by shaking them, and then drowned in five times their weight of alcohol."

Dr. Hale triturates the posterior third of the bee, ten bees to 90 grains of milk-sugar; or he makes a tincture by pouring boiling water on the bees, one-tenth part of alcohol being added as a preservative.

Dr. Alb draws out the sting and poison bag and triturates it with sugar of milk.

Dr. Marcy dries the bees at a temperature of 90° and triturates them with sugar of milk.

Dr. Hering much ridicules this latter preparation of Dr. Marcy; and directs the bee to be caught by the wings with a pair of forceps, and caused to deposit its poison on a glass or piece of sugar, to be dissolved in alcohol, or triturated, respectively.

Dr. Ludowski causes the bee to sting the patient, thus administering the crude drug hypodermically.

"For the sake of remarkability and completeness we have yet to mention the poison of the queen bee. In the stately gathering of homœopathic physicians at Dortmund, Dr. Lippe remarked, 'that the poison of the queen bee had proved the most efficient remedy in jealousy of women; for the reason, perhaps, that it is the most jealous creature in the world—one which will not tolerate a rival.' What a pity Desdemona did not know of this wonderful remedy." —(Dr. Goullon.)

*Bibliography.*—Farrington's Clinical Mat. Med.; Hughes's Pharmacodynamics; Hom. Observer, 1864, vol. i.; Metcalf's Provings, 1853; American Journal of Hom., vol. x.; Trans. World's Hom. Convention, 1876; Kirby and Spence, Introduction to Entomology; New Cyclopædia of Drug Pathogenesis; Encycl. Britannica.

#### REMARKS ON PROVINGS.

Since the explosion of the old idea that animal poisons are inocuous when swallowed, we are not surprised to learn that apium virus produces its characteristic effects upon the human organism whether introduced through the stomach, or directly into the circulation by the hypodermic end of the "busy bee." The only difference is that the effects of the latter are more intense, not only locally but generally.

The pathogenesis herein given is, therefore, due indiscriminately to both modes of administration.

In studying the effects of apium virus the records found in the *Cyclopædia of Drug Pathogenesis* have all been used, excepting the following :

No. 2. A married woman (*Amer. Arzneiprüfungen*). Her symptoms are too questionable.

No. 8b. Miss —, æt. 40. A clinical case. Apis was given for ovarian tumors.

No. 12. Swammerdam. A record of a few local effects.

All the poison, or sting cases, have been utilized, excepting Nos. 15 and 16, which are respectively the results of a "yellow-jacket" sting, and the results of a wasp sting.

In addition to the records in the *Cyclopædia of Drug Pathogenesis*, we have made use of six other cases, the first five of which are from stings, viz: A "Bee-Poisoning," by Dr. Dake, of Pittsburgh, reported in the *North American Journal of Homœopathy*, vol. vi., p. 385 ; a case by Dr. Bell, of Maine, published in the *HAHNEMANNIAN MONTHLY*, vol. vi., p. 360 ; a record from Dr. Samuel Deans, of Massachusetts, in the *N. E. Med. Gazette*, vol. ii., p. 234 ; a case related by Dr. Marcy and published by Dr. Lilienthal in the *North American Journal of Homœopathy*, vol. xvi., p. 501 ; a case reported by Caroline E. Hastings, M.D., of Boston, Mass., in the *N. E. Med. Gazette*, vol., xxii., p. 515 (November, 1887) ; a fragmentary proving by an allopathic physician, reported in the *Homœopathic Recorder*, vol. iii., p. 259 (November 15, 1888).

Besides the effects of the bee stings, the provings recorded in the *Cyclopædia of Drug Pathogenesis* were obtained from the pure virus, a tincture of the whole bee ; a tincture, the manner of preparation of which is not stated, the 1st, 2d, 3d and 6th dilutions.

The pathogenesis of apis is synthesized from thirty-three provings, of which twenty-two are the results of stings and eleven the effects of administration by the mouth.

Although it is supposable that few persons are not more or less susceptible to the virus of the honey-bee, whether it be ingested or subcutaneously injected, it nevertheless seems to be a fact that there are some individuals who are not affected by the poison, if we can rely upon the testimony of Dr. James Lembke, of Riga. He tried on himself the 1st and the tincture, from November 11 to December 14, 1858, without result. Ten other persons had the tincture given them "to the amount of 1 scruple to 2 drachms in the course of from two to five days. In these cases the result was null." The tincture is said to have been a good one, from a first-class pharmacy.

Whether there are few or many who are subject to the influence of apis is a question of interest and importance to the future pharmacometer of the drug, but as the experimenters whose work we have analyzed certainly were susceptible, Dr. Lembke's observations have no bearing upon the vitality of our present effort.

Among the poisoning cases studied, none were fatal, and hence we have no post-mortem appearances to assist us in defining the general sphere of the drug's action. Much has been written about the general sphere of action of apis, but it is largely assumption. Though possibly sustained by supposed experience at the bed-side, a synthesis of effects, such only as our strict method allows, shows the common conception of the general sphere of the drug to have a very circumscribed pathogenetic foundation. For example, we have not found among all the provers one symptom indicative of disturbance in woman's sexual system. The apis of our symptomatology has no ovarian pathogeny.

Apium virus is not a long-acting, nor is it especially a deep-acting, poison, though its effects may be violent while they last, and, as may be supposed, it is of less importance in chronic than in acute diseases.

#### GENERAL SPHERE OF ACTION.

Apium virus acts pre-eminently upon the vegetative nervous system. There is a diminution of vital force, indicated by weakness, which may amount to prostration.

The circulation becomes weak, and sufficient sanguineous stasis ensues to produce œdema, which may be either general or circumscribed. The cardiac weakness may also be accompanied by dyspnoea.

The skin and mucous membranes are affected. The former is covered with a rash which itches violently, and sometimes œdema accompanies. There is irritation of the mucous membranes with an underlying œdema also. In consequence, from the alimentary canal there is emesis, or there are copious dejections; or, if the swelling extends down the respiratory tract, there will be dyspnoea.

The urinary apparatus also suffers from the virus, but not so severely as many symptomatologists would lead us to suppose.

From the mental condition and the headache of some of the provers, we judge that apis produces an irritation of the cerebro-spinal centres. A fair inference is that the brain is too full of blood.

## SYMPTOMATOLOGY.

(Provers, 33 : Men, 23 ; women, 7 ; children, 3.)

*Generalities.*

A strange feeling throughout the whole body.\* \*  
Restlessness ;<sup>5</sup> lassitude ;<sup>5</sup> weakness ;<sup>4</sup> weakness and trembling.<sup>1</sup>  
Prostration :<sup>4</sup> extreme.<sup>1</sup>  
General sore, bruised feeling.<sup>5</sup>  
Swelling of the whole body ;<sup>1</sup> face, neck and limbs swollen.<sup>1</sup>  
Twitching of muscles.<sup>3</sup>  
Sensation of heat of whole body.<sup>3</sup>

*Mind.*

Mental agitation ;<sup>6</sup> Anxiety :<sup>4</sup> great ;<sup>3</sup> irritable humor.<sup>3</sup>  
Mental confusion :<sup>4</sup> semi-consciousness.<sup>1</sup>  
Depression.<sup>3</sup>

*Head.*

Confusion of head ;<sup>5</sup> vertigo.<sup>4</sup> (Probably from congestion in three.)  
Headache :<sup>11</sup> dull,<sup>6</sup> of whom three had dull, heavy ache ; sharp ;<sup>4</sup>  
pressive ;<sup>3</sup> in forehead ;<sup>3</sup> sinciput ;<sup>3</sup> side of head,<sup>6</sup> of whom three  
were on left side ; temple,<sup>6</sup> four of whom in both temples ; occiput.<sup>3</sup>  
Sensation of pressure in head ;<sup>3</sup> of fulness.<sup>3</sup>  
Head feels big.<sup>3</sup>

*Eyes.*

Pricking itching of eyelids ;<sup>3</sup> agglutination of eyelids.<sup>3</sup>  
Eyelids swollen :<sup>4</sup> completely closed.<sup>1</sup>  
Irritation of edges of lids.<sup>4</sup>  
Pricking itching of left inner canthus.<sup>3</sup>  
Eyes watery.<sup>6</sup>  
Pain in eyeballs ;<sup>3</sup> swollen feeling about left eye ;<sup>3</sup> pain over eye.<sup>2</sup>  
Dimness of vision.<sup>3</sup>

*Nose.*

Nose swollen ;<sup>1</sup> stoppage of nose.<sup>1</sup>  
Watery discharge from the nose ;<sup>3</sup> sneezing ;<sup>3</sup> with watery eyes.<sup>3</sup>

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\* This was expressed by the five provers differently, as follows: "Sickly feeling ;" "felt very unwell ;" "indescribable sensation through whole body ;" "felt so queer that she thought she would die ;" "complained of a very strange feeling which she could not define."

*Face.*

The whole face is swollen ;<sup>3</sup> sensation of pricking in the face.<sup>8</sup>  
 The face is hot,<sup>8</sup> red,<sup>4</sup> purple,<sup>4</sup> pale.<sup>2</sup> (In two of these provers it was first red and afterwards became purple.)  
 Burning on chin and cheek-bones.<sup>2</sup>

*Mouth ; Teeth ; Tongue, etc.*

Dryness of the mouth.<sup>2</sup>  
 Secretion of thick, viscid saliva.<sup>2</sup>  
 The upper lip is swollen.<sup>2</sup>  
 Pain in tooth.<sup>2</sup>  
 Tongue feels as if burnt.<sup>2</sup>

*Throat.*

Secretion of thick mucus in the pharynx.<sup>2</sup>  
 Throat irritated :<sup>5</sup> a raw feeling.<sup>2</sup>  
 Sensation of constriction in the throat ;<sup>4</sup> dysphagia.<sup>2</sup>

*Stomach.*

Diminished appetite.<sup>2</sup>  
 Great thirst.<sup>2</sup>  
 Eructations :<sup>4</sup> violent eructations.<sup>2</sup>  
 Nausea :<sup>8</sup> nausea and vomiting ;<sup>3</sup> nausea in the throat.<sup>2</sup>  
 Vomiting :<sup>5</sup> violent vomiting ;<sup>2</sup> vomiting of bitter fluid ;<sup>3</sup> vomiting and diarrhoea.<sup>2</sup>  
 Sense of discomfort in the stomach :<sup>5</sup> expressed variously, as soreness, a pricking pain, heat, pressure, oppression.

*Abdomen.*

Pain in the abdomen.<sup>6</sup>  
 Rumbling in the abdomen with sensation as of approaching diarrhoea ;<sup>2</sup> abdomen swollen.<sup>2</sup>

*Stool.*

Diarrhoea :<sup>10</sup> stools yellow,<sup>2</sup> watery,<sup>4</sup> yellow and watery,<sup>2</sup> copious,<sup>3</sup> of pappy consistence,<sup>2</sup> lumpy,<sup>2</sup> with tenesmus.<sup>2</sup>  
 Emission of flatus.<sup>2</sup>

*Urinary Organs.*

Burning in the urethra :<sup>4</sup> during micturition.<sup>2</sup>  
 Frequent micturition :<sup>7</sup> frequent micturition at night ;<sup>2</sup> urging to urinate.<sup>2</sup>  
 Urinary secretion scanty.<sup>2</sup>

*Sexual Organs.*

*Male:* Uneasy sensation in spermatic cord.<sup>2</sup>

Sexual excitement.<sup>3</sup>

*Respiratory Organs.*

Hoarseness;<sup>2</sup> larynx sensitive;<sup>1</sup> violent cough.<sup>2</sup>

Irritation in the trachea.<sup>3</sup>

An itching, tingling sensation crept down the bronchial tubes, apparently as far as they extend;<sup>3</sup> sensation of swelling of the air passages.<sup>2</sup>

Dyspnœa:<sup>13</sup> two provers specified rapid breathing, and two specified asthmatic breathing.

*Chest.*

Oppression of the chest;<sup>2</sup> bruised sensation in the chest.<sup>2</sup>

Pains in the chest;<sup>6</sup> in left side of chest;<sup>2</sup> stinging pains through chest.<sup>4</sup>

*Heart and Pulse.*

Pain in the region of the heart,<sup>3</sup> accompanied by dyspnœa.<sup>2</sup>

Palpitation of the heart.<sup>2</sup>

Pulse accelerated;<sup>5</sup> weak;<sup>4</sup> rapid and feeble;<sup>4</sup> scarcely discernible at the wrist.<sup>3</sup>

*Neck and Back.*

Tension in the nape of the neck.<sup>3</sup>

Acute pain in the nape of the neck;<sup>3</sup> tensive in character and extending from the nape to behind the left ear, and spreading over the left side of the head.<sup>2</sup>

Painful stitch in the right side of the nape of the neck.<sup>2</sup>

Stitches through the chest and back at night.<sup>2</sup>

*Limbs.*

Cold limbs;<sup>2</sup> cold extremities;<sup>2</sup> twitching of muscles of extremities.<sup>1</sup>

Tensive pain in the left shoulder.<sup>2</sup>

Sensation of burning in palms of hands;<sup>2</sup> sensation of pricking in palms of hands;<sup>2</sup> sensation of prickling in palms and on backs of hands.<sup>2</sup>

Numbness of fingers;<sup>2</sup> sensation of burning in finger-tips.<sup>2</sup>

Sensation of soreness in the legs.<sup>2</sup>

Feet swollen;<sup>3</sup> feet found swollen at night on removing boots and stockings.<sup>2</sup>

Sensation of burning in the feet.<sup>2</sup>

Cold feet.<sup>2</sup>

### *Skin.*

Irritation of skin of body;<sup>18</sup> itching;<sup>2</sup> (itching in circumscribed spots);<sup>2</sup> stinging;<sup>4</sup> prickling;<sup>3</sup> pricking;<sup>2</sup> a rash over the skin;<sup>11</sup> (itching of the rash;<sup>4</sup> red rash;<sup>3</sup> white rash;<sup>3</sup> eruption like "nettle-rash;"<sup>4</sup> red and white spots).<sup>2</sup>

Sensation of heat over surface of body.<sup>7</sup>

### *Sleep.*

Sleepiness;<sup>4</sup> great desire to sleep.<sup>2</sup>

Restless sleep at night;<sup>2</sup> dreamful sleep;<sup>3</sup> full of care and trouble.<sup>2</sup>

### *Chill, Fever, Sweat.*

Rigor;<sup>6</sup> chilliness.<sup>2</sup>

Fever;<sup>2</sup> sensation of heat;<sup>8</sup> flushes of heat.<sup>2</sup>

General sweat.<sup>2</sup>

### *Aggravation.*

Motion aggravates the headache.<sup>4</sup>

### *Amelioration.*

Headache relieved by compressing head with hands;<sup>8</sup> (this ache was a "throbbing" ache in two provers).

. Twitching of muscles relieved by bathing feet in warm water.<sup>2</sup>

## THERAPEUTIC APPLICATIONS.

Some of the pathological conditions for which apium virus is suggested by the foregoing symptomatology are as follows:

*Angina Faucium.*—The pharynx feels irritated, a thick mucus is secreted, and accompanying is a sense of constriction, with dysphagia. There is prostration, chilliness, and sometimes aching of the muscles of the trunk and limbs. Nausea is also sometimes present. From these symptoms, apis is suggested in *diphtheritis*.

In *coryza* the drug may also be studied.

*Diarrhoea.*—The stools are copious in this affection, yellow and watery; sometimes pappy, sometimes lumpy. Tenesmus and flatus are also concomitants.

*Dysuria.*—In dysuria the urinary secretion is scanty; there is



urging to urinate, with frequent micturition, during which there is burning in the urethra.

*Cutaneous Erysipelas.*—In cutaneous erysipelas the drug is better indicated than when the underlying tissues become affected. Accompanying is a sensation of burning, stinging, pricking or itching of the skin, and there is also a sore, bruised feeling, with œdematous swelling. If the face is the focus of the disease, it will probably be œdematous, sometimes to the extent of closing the eyes, and the skin will be almost any degree of red, from pink to purple. Mentally, the patient may be irritable, anxious, or he may lapse into stupor from extension of the disease to the cerebral meninges.

*Urticaria.*—In this irritating affection the wheals may be red or they may be white. They vary in size from a mustard seed to elevations that cover several square inches. Intense itching is rarely if ever absent.

The more nearly the wheals resemble bee stings in appearance, the more certain is apis to give relief.

*Inferentially*, apis is suggested in *œdema glottidis*, *pulmonary œdema*, *rheumatism* and *intermittent fever*.

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## THE TREATMENT OF PARASITIC DISEASES OF THE SKIN.

BY EDWARD M. GRAMM, M.D., PHILADELPHIA.

(Read before the Philadelphia County Homœopathic Medical Society.)

MR. PRESIDENT:—There are very few physicians who have graduated from a homœopathic college, if they have done so because they firmly believe that *similia similibus curantur* is a law of nature, who do not enter upon practice with the opinion that it is only necessary to administer the indicated homœopathic remedy in any and all diseases to bring about a cure in the most rapid, pleasant, and permanent manner. Your speaker was one of those at the time of his graduation (and he still believes that the only guide to the internal administration of remedies is to be found in the law formulated by Hahnemann, and the corollaries of that law, *i.e.*, the single remedy and the smallest dose necessary to bring about a cure). Following out those convictions he determined to treat skin diseases in

the College Dispensary in what is usually denominated the strict Hahnemannian method.

Parasitic diseases soon proved to be presenting themselves in increasing ratio to the number of diseases treated, and were observed with a great deal of interest on account of the positive statements to be found in our literature in reference to the remedies which would cure them if administered alone and without the employment of any accessory means (local applications). Ringworm, chromophytosis, and itch were treated according to the indications which the patients suffering from them presented. Unfortunately, it has not been my good fortune to have had any cases of favus under my sole care; those for which I have been called upon to prescribe having been seen in consultation in the practice of other physicians.

The three diseases just mentioned were soon found to be rebellious to the treatment employed, all of them continuing to spread and manifest remarkable vigor. In consequence the subjects of the diseases would return time and again with the report that no visible improvement in the skin lesions had manifested itself, although I can recall numerous cases in which the general health became very much better under the remedies prescribed. This fact proves that it would be a very lame claim for any one to make that the *similimum* to the case had not been administered. If such had been the case, why could constitutional symptoms disappear and demonstrable disease signs melt away while the patient was following the mode of living, etc., during the treatment that he had followed before coming under observation? It seems to me that the conclusion that the facts observed must lead to is, that it is necessary to employ other means in addition to the internal ones. An answer that will be made to this statement is, that it is necessary to so alter the soil in which the parasites, which are the cause of these diseases, vegetate, that they can no longer find sustenance there, and thus compel them to die of starvation, or seek quarters in which the pabulum on which they feed is constantly being produced. I heartily agree with that idea; but I am also firmly convinced that it is first necessary to remove the colony of parasites which are the cause of the secondary changes in the skin that are the evidence of their presence, or, at least, to do so simultaneously with the improvement of the soil. Killing off the parasites, or making the region of skin that they have invaded temporarily untenable by them, is the province of the various drugs to be applied locally, which are denominated parasitocides. The function of remedies administered internally is to re-

move any disease manifestations of which the patient complains. The removal of the morbid symptoms will inevitably be followed, not only by a restoration of systemic health, but will also result in restoring the skin to such a condition that a new invasion by parasites will not be possible, for the pabulum necessary for their existence and propagation will not be developed in it. Theoretically, it certainly seems the best plan to accomplish the restoration of the normal condition of the skin by internal means alone; but where is the patient who is willing to await the result of such a method of treatment? Practically no danger to the general health, whether immediate or ultimate, is incurred by an intelligent and careful use of drugs applied externally. No one would for a moment question the fact that grave harm can be done by using external applications too strong, or for too long a time. The same or greater injury would follow such a use of them internally.

Having thus made my position clear in reference to the treatment of this class of diseases, I will proceed to outline the course which has proved itself of service to me, and following the application of which I have yet to see the first instance in which the use of drugs externally has produced systemic disturbances. I have carefully sought for evidence which might prove me mistaken in my opinion that parasitocides are necessary and harmless if properly used.

So far as the treatment of vegetable parasitic diseases is concerned, there are certain principles which can be considered in a class. The first problem of a rational treatment is found in the removal of all debris, whether this is the primary production of the fungus (such as the favus cups), or is the secondary effect of its presence upon or within the skin (such as the crusts following the breaking down of the pustules of ringworm of the beard). This is to be accomplished without the use of water or by using as little as possible. The reason for recommending such a procedure is found in the results of recent investigations by H. Leslie Roberts into the propagation of the trichophyton, which have established the fact that fluid culture media favor its development, even to the production of fructification organs, while more solid media are unfavorable to its development to such a point. On that account the skin is not the best soil in which it can vegetate, and we should not apply to the skin anything which will make it a better feeding ground for the parasite. Crusts produced in these diseases can best be removed in the manner recommended by Shoemaker. He first soaks them thoroughly with olive oil, sweet almond oil, or oil of ergot. When they have become

thoroughly impregnated with the oil they are removed by washing them with a 50 per cent. solution of boro-glyceride in glycerine, or with pure glycerine. I have most frequently employed the latter, and have found it very efficacious. After the surface has been cleansed by the oil and glycerine some parasiticide must be applied.

Passing now to a separate consideration of the vegetable parasitic diseases, ringworm claims our attention first on account of the frequency with which it is presented to us for treatment. In this disease I have used as external applications bichloride of mercury, two grains to the ounce of alcohol or cologne spirits; oleate of copper, 30 grains to the ounce of lard, or equal parts of lanoline and lard; salicylic acid, 1 drachm to the ounce of alcohol; boro-glyceride, a 50 per cent. solution in glycerine; and pure glycerine.

The boro-glyceride and glycerine have such an affinity for water that they almost immediately enter into combination with it in the tissues of the skin, and thus deprive the fungus of the water which it requires for its existence, in consequence of which it dies. If any physician has any scruples in reference to applying any active medicinal agents to the skin, these two substances offer him a way out of the dilemma. Another method of treatment, which is not directly medicinal, is based upon the fact that the ringworm fungus requires air for its existence. Sealing the patch of disease by any impervious dressing meets these indications. I am experimenting at the present time with applications of flexible collodion and tincture of benzoin, concerning which I am not yet prepared to offer any definite facts; but I will say that I have already seen some encouraging results.

Recently Dr. Wessinger has reported a series of cases of ringworm which he cured in from four to ten sittings by the application of the galvanic current.

I have not of late practiced depilation for the purpose of hastening the cure. Almost all authors recommend that it should be done; but an attempt to remove the hairs affected by the trichophyton will convince any one of the futility of his endeavor to completely remove the brittle hairs. Shoemaker, of this city, and Vidal are authorities who advise against depilation.

Many of the cases which come under treatment can be cured rapidly, but there are others which run a protracted course in spite of the most careful attention to the details of treatment. This fact has led Besnier to claim that parasiticides are useless, and that an expectant treatment should be applied. His idea is that the affected region should be sterilized and kept so.

Chromophytosis should offer no difficulties in its removal. A correct diagnosis is essential in treating this affection, as a careless examination is usually the cause of a protracted course of internal treatment for "liver spots," when the liver has nothing to do with the production of the skin lesions. Chloasmata are invariably of pigmentary origin, and are located within the epidermis instead of upon it. I have had patients to recover from this slowly-developing affection in what seemed to them a ridiculously short space of time after the years that they had spent in endeavoring to have it removed by remedies directed against supposed maladies of internal organs.

The plan to be pursued is as follows: The patient is directed to first wash the affected region with a strong soap (dispensary patients are told to use some common scrubbing soap; people of the better class should be given a prescription for the spirit of green soap of Hebra, which consists of two parts of green soap and one of alcohol, the fluid being filtered before it is dispensed). The superficial layers of the epidermic cells having been removed by this procedure, I am in the habit of having the hyposulphite of sodium, one drachm to the ounce of water, applied with a piece of flannel. This drug is generally sufficient to accomplish the removal of the cells which the parasite has invaded. Should any further treatment be required, salicylic acid in alcohol will remove the disease. Relapses are frequent on account of discontinuing the local applications too soon. They do not occur if care is taken to examine the epidermis of the affected area from time to time under the microscope.

Favus will give the most trouble in its cure. The stronger parasitocides should be used in combating it. Of these, bichloride of mercury, two grains to the ounce of water or cologne spirit, stands first; boro-glyceride and glycerine should, however, not be forgotten, as the fungus which produces the disease needs water to keep it living, just as the ring-worm fungus does. The achorion Schoenleinii can grow without air, hence it will not be killed if it is covered with an impervious dressing. One point in the treatment that must not be forgotten is, that in the beginning of their existence the favus cups or scutula are covered with a layer of epidermis that must be ruptured before the parasiticide can penetrate them.

There are but two animal parasitic diseases of the skin that need engage our attention to-night, as the others are rare, and, in some instances limited to a particular section of country. I will state, in passing, that during the past summer a large number of children were

brought to the dispensary who were covered with flea-bites. There seems to have been an epidemic of fleas this year in this and other cities.

The two diseases that I will speak of are the louse disease and itch. The former of these, pediculosis, is very amenable to treatment if the patients can be brought to follow the directions vigorously and systematically. For killing the lice, I generally order that the heads of the children affected be washed in tobacco infusion made out of tobacco stems, which can generally be obtained for the asking. This infusion, and all liquid preparations, are only to be used when there are no evidences of pustulation, which develops after lice have been present some time. A tincture of *staphysagria* or *coccus* is also efficacious under similar circumstances. Chloroform and ether can also be used to remove the lice; but when ether is used the lice must be washed off with it into a basin of water and subsequently killed, as it merely stupefies them for a time. Where pustulation has already been produced it is necessary that *staphysagria* in a powdered condition be dusted upon the scalp.

When a careful examination of the parts shows that no more lice are present, it becomes necessary to use some remedy to remove the nits, which seem rather to enjoy than to dislike the measures that are baneful to the fully developed louse. For the purpose of removing them, for they are glued to the hairs by a remarkably strong cement-substance, the hair should be washed with vinegar, alcohol, or borax dissolved in water. These measures should be repeated over and over again until no more nits can be found.

Scabies or itch is not at all a formidable disease to deal with when carefully treated. I have never seen any person who had suffered from this disease, and in whom a cure of the itch had been effected by killing the itch-mites and their eggs by local applications, whose general health deteriorated in any way in consequence thereof. The treatment to which I subject a patient who comes under my care is as follows: He is told to take a bath at night on going to bed, using a strong soap, and to follow it with quite hard rubbing with a coarse towel. Having by such a procedure removed as much of the epidermis as possible, and, in some instances, opened a few of the burrows made by the itch-mite as receptacles for its eggs, this ointment is rubbed into all portions of the skin except that of the face and scalp, and particularly into the sites of predilection, *i.e.*, the webs of the fingers, the axillæ, the groins, and between the toes:

R. B. naphtholi,	. . . . .	1 drachm,
Adipis,	. . . . .	2 ounces,
Saponis viridis,	. . . . .	1 ounce,
Crete præcip.,	. . . . .	$\frac{1}{2}$ drachm.
M. et ft. ungt.		

The ointment is left *in situ* until the next night, when another bath is taken and another application of the ointment made. The third night the same procedure is necessary, and on the fourth night a final bath is taken. When the patient reports for examination on the fifth day it but rarely occurs that any new canaliculi can be found, and the old ones have a shrivelled look. If the patients are too poor to buy the naphthol ointment, I let them get sulphur ointment and use that in the same manner as the former. I do not, however, obtain as good results from it as from the naphthol ointment.

Naturally, it is impossible to remove all traces of irritation of the skin in five days. A dermatitis or eczema remains, that must be treated according to the indications presented by the patient; and it generally yields very readily to the exhibition of internal remedies.

#### INTERNAL TREATMENT.

It is as impossible to mention certain remedies as having the ability to invariably cure parasitic diseases as it is impossible to state that certain others have such a specific action in pneumonia; for instance, it is necessary in all forms of disease, whether of the skin or of internal organs, to search for the remedy that covers the totality of the symptoms of which the patient complains.

Calcar., sepia, and tellur. are much vaunted for their ability to cure ringworm. I have administered all three of them very many times, and have found them curative where systemic symptoms indicated a necessity for them, and under no other circumstances, just what every homœopathic physician has found to be true of all of the remedies of the *materia medica*. So many remedies have been administered to different patients with success, that I would not like to mention any one or more as being oftenest indicated.

In chromophytosis I have been in the habit of giving those remedies the first rank in importance that have produced brownish discoloration of the skin; antim. crud., carbo. veg., lycop., mezer., nitr. ac., phosph., sepia, and thuja, are some of them.

Of favus I can say nothing from experience.

In pediculosis I make no endeavor to treat the disease by a certain line of remedies merely because lice are the exciting cause of

the skin lesions. Oleand., viola tric., and hepar, relieve the pustulation of the disease. Croton tigl. and graphit. are also to be thought of if the inflammatory symptoms are severe.

If there are any remedies in our materia medica that should be thought of above all others in an acute eczema, such as is sometimes seen to be produced by the ravages of the itch-mites, they are hepar and croton tigl. Sulphur is given too high a rank in the treatment of itch. If a case drags along too slowly, psorin. will often start up a reaction. Cinnabar is useful in the itching, aggravated at night, where there are no symptoms to contraindicate it.

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## THE DIAGNOSTIC SIGNIFICANCE OF THE TENDON REFLEXES.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA.

(Read before the Philadelphia County Homoeopathic Medical Society.)

A PROPER understanding of the various tendon reflexes is invaluable in the investigation of diseases of the nervous system, not only of those of the brain, spinal cord and peripheral nerves, but also of those of functional origin. Because of this, and because I have several times been asked by professional friends to prepare a paper on this subject, I present the following remarks this evening. While they will be found to embrace nothing that is new, I trust that the exposition of the subject will not be devoid of interest. I have several times heard and read expressions of opinion from prominent physicians stating their lack of appreciation of the value of the tendon reflexes in diagnosis. Such a depreciation of a valuable clinical sign should not be countenanced. So fully impressed am I with the importance of a knowledge of the condition of the tendon reflexes in disease, that I feel an examination into their condition should be a routine measure in the investigation of all cases of nervous disorders.

A proper understanding of the methods by which the patellar tendon reflex is elicited is in order. The method most commonly in use is the following: The patient should be seated. The knees should be bared. Then the leg to be examined should be thrown over its fellow, and allowed to hang as if lifeless, so that no involuntary rigidity shall be permitted to interfere with the reaction. Then with the outer edge of the hand, or with a percussion hammer, or the



edge of the ear-piece of a stethoscope, a smart blow should be applied to the ligamentum patellæ, just below its insertion into the patella ; when in health, a vigorous contraction of the quadriceps extensor ensues, and the foot is jerked suddenly upwards. In applying the test, baring of the knees is absolutely necessary for the sake of accuracy in observation ; especially is this so in cases in which the blow applied through the clothing has failed to elicit a response. It cannot be conclusively stated that the patellar reflex is absent in any given case unless this be done. No less important is the injunction that the limb examined be held perfectly limp and lifeless. Frequently have I seen cases in which the patellar tendon reflex had been declared to be absent simply because the precaution of securing perfect relaxation of the limb had been neglected. There are cases in which this is a difficult matter, owing to the inability of the patient to fix his attention away from the operator's movements. In such it has been my custom to adopt the device first suggested by Jendrassik, to semi-flex the hands, hook them together and exert strong traction. While this is being done, the blow is applied to the ligamentum patellæ as before, when, if the knee-jerk be present, it is readily elicited. Any other voluntary movement made by the patient will secure the same object. Thus, asking the patient to count aloud, or to look into vacancy and wink rapidly, and while the physician applies the blow to the ligamentum patellæ, will secure a response as readily as by the method of Jendrassik.

In very stout persons the above method of applying the patellar reflex is impracticable owing to their inability to sit with legs crossed. In such cases the patient should be directed to sit on the edge of a table or desk with the legs dangling over. A blow applied to the ligamentum patellæ, as in the previously described method, produces the knee-jerk.

Yet another method for obtaining the knee-jerk, first suggested by Buzzard, may be adopted. It is a method particularly convenient in the case of examination of women. The patient is directed to sit with the legs flexed at an obtuse angle at the knee, with the feet resting upon the floor. A blow applied to the ligamentum patellæ will excite a vigorous contraction of the quadriceps extensor, which will be appreciated by the examiner by having his free hand resting on the thigh at the moment the blow is applied. In male patients the contraction will be readily noticed by the eye.

Cases will frequently occur in the practice of all of us in which the patient's illness is of such a nature as to make it impossible to

get him out of bed to apply one of the above described tests. We may then resort to one of the following methods, the results from the first of which are only satisfactory in cases in which the reflex is perfectly up to the normal or excessive. The patient is directed to lie on the back with the legs extended. The operator then applies the forefinger of one hand to the upper edge of the patella, and exerts strong downward pressure, that is pressure in the direction of the long axis of the limb, towards the foot. Then a sharp blow is applied to the finger, preferably with a percussion hammer, in the direction of the pressure exerted. If the reflex be present, a jerking upwards of the patella follows.

The preferable method for the examination of the patient when in the recumbent position is that first suggested by Dr. Angel Money. The thigh is flexed at right angles with the body, and the knee at nearly a right angle with the thigh; the foot is then supported loosely in the palm of the operator's hand, as in a stirrup, care being taken that the patient exert no effort to maintain the limb in this position. A blow is then applied to the ligamentum patellæ, as in the other methods of examination; the knee-jerk then takes place.

The directions above given for the obtaining of the patellar reflex are by no means superfluous, though it would at first sight seem so. A phenomenon that has for ages been used by mischievous school-boys requires no care for its investigation on the part of the physician, it might be thought. Such, however, is not the fact. I can assure you that I have repeatedly seen instances in which carelessness in applying the tests has led the observer to declare the patellar reflex absent, when it was readily obtainable, and present when it was certainly absent. The latter error is the more infrequent. It occasionally arises, however, from the confusion of the swinging movement resulting directly from the force of the blow, with true knee-jerk. If the difference in the character of the two movements is borne in mind, no mistake should be made.

The knee-jerk may also be declared to be present, when it is absent in certain cases in which the cutaneous reflexes are excessive. The response in this case is the result of irritation of the skin over the ligamentum patellæ, and not of the blow applied to the tendon itself. In cases of this kind, the efforts to obtain the reflex are not all equally successful, and the resulting movement is not always of the same character, sometimes being in the extensors, and at others in the flexors.

The patellar tendon reflex is so constantly present in health, that

its absence may be regarded as of pathological import. For some time it was thought that in about 1 per cent. of all individuals this reflex could not be obtained. Since, however, the discovery of Jendrassik's method of eliciting the phenomenon, the theory that absence of the patellar tendon reflex was sometimes physiological has been abandoned. Jendrassik, himself, examined one thousand men of different ages for the purpose of deciding this very point. His subjects were either healthy individuals or were suffering from diseases other than those of the nervous system. Of these, the knee-jerk was obtainable in all but one, and that patient was the subject of diabetes, in which disease the phenomenon under study is frequently absent, as I shall show presently.

I have myself met with but two presumably healthy subjects in whom the knee-jerks were not obtainable. In the first of these the observation is without value, as the test was applied without barring the knee or adopting the method suggested by Jendrassik; in the second I succeeded in obtaining the reflex one year ago only after the greatest care; a more recent observation failed to elicit any result. It is now the generally received opinion, with which I am in full accord, that the absence of the patellar tendon reflexes is always significant of disease, with the exception of those cases in which some abnormality in the knee-joint exists to account for such absence.

In making this statement I do not wish to convey the idea that the absence of the patellar tendon reflex is a forerunner of serious and progressive disease. While its absence should lead to care in the search for other symptoms, it should be borne in mind that it may ever remain the only outward sign of a slight and unprogressive lesion. About five years ago my attention was called to the inequality of the pupils of a brother practitioner. A most carefully conducted examination revealed only Argyll-Robertson pupils, absence of both patellar reflexes, and a very slight static ataxia. Now, while there can be no question of the fact that that man is suffering from incipient locomotor ataxia, it is interesting to note that his condition to-day is not perceptibly worse than it was five years ago.

As a result of disease, we may have the patellar tendon reflex either diminished, destroyed, increased, or altered; by alteration I refer to the imperfectly understood phenomenon known as the transferred patellar reflex. A case of this kind was reported by Dr. Allen McLane Hamilton, of New York. A blow applied to the left patellar tendon produced a knee-jerk on the right side, while the limb

on the same side was perfectly quiet. A similar result was obtained by percussing the right patellar tendon.

In order to better explain the *rationale* of the disappearance of the tendon reflex in nervous disorders I shall give a short description of the reflex arc on the integrity of which the reflex depends. When the ligamentum patellæ is struck, the impulse thus generated is carried by the sensory fibres of the nerve to the spinal cord, entering the same by the posterior root and the posterior root zone. It is thence carried to the ganglion cells in the anterior cornu. Now a motor impulse is generated, which traverses the anterior roots, and reaches the muscle by means of the motor fibres of the nerve. Any pathological condition which causes a break or loss of integrity of this arc destroys the tendon reflex. In general terms we may say then, that absence of the patellar tendon reflex signifies disease of the peripheral nerve (anterior crural), or of the posterior root zones or the anterior gray horn in the lumbar enlargement. It may also be absent in some cases of epilepsy, in certain disorders of the muscular apparatus, and in meningitis, as we shall see presently.

The extent of the jerk in response to the blow on the patella is regulated by the inhibitory influence of the cerebrum. This influence is exerted, or rather transmitted, through the pyramidal tracts. Disease of this portion of the spinal cord is, therefore, attended by marked exaggerations of the knee-jerks, because the inhibitory influence of the cerebrum is wholly or partially removed.

Before proceeding to the consideration of the diseases in which the patellar tendon reflex is altered or departs from the normal, a few remarks as to the variations to which it is subject in health will be in order. These changes, however, are not such as to affect the value of investigation of the condition of the tendon reflexes in health disease. Jendrassik was the first to call attention to the fact that a certain muscular exertion would increase the knee-jerk. Mitchell and Lewis, carrying his investigation further, found that any muscular exertion made at the time the blow was applied to the tendon caused an increase in the response. Even as slight a movement as winking the eyes would lead to the production of a strong knee-jerk in cases where it had been previously weak. Even sensory stimuli, as the prick of a pin, the application of the faradic brush, the pulling of a hair, had the same effect. Knapp, of Boston, found that if the knee-jerk was tested within 0.4'' after the muscular exertion or the application of the sensory stimulus, the jerk was increased; but if after that period, then it was diminished.

Lombard, in his investigations, confirmed all that had been previously stated by Mitchell and Lewis. He found also that the tendon reflexes were liable to certain variations in healthy individuals. Thus agencies which increase the activity of the central nervous system, as rest, nourishment, invigorating weather and wakefulness increase the reflex; while depressing influences, as fatigue, hunger, enervating weather and sleep exert a contrary effect. He also noticed variations along with the condition of the atmospheric pressure and temperature. In general it might be stated that it increased with the rise in the barometer, and with the fall of the thermometer, and *vice versa*.

Taking up *seriatim* the various diseased conditions which destroy the integrity of the reflex arc governing the production of the patellar reflex, we come first to diseases of the peripheral nerve, the anterior crural. Prominent among these is neuritis, in which disease it is almost always lost. It is owing to neuritis affecting this nerve that the patellar tendon reflex is absent in cases of diphtheritic paralysis. The time of appearance of this symptom varies with different cases. In some it is the first to make its advent; in fact, it may be the only symptom for a long time. The almost invariable absence of the knee-jerk in diphtheritic paralysis must be kept in mind, otherwise the ataxic gait, which sometimes accompanies this disease, may lead, in conjunction with it, to the diagnosis of locomotor ataxia. The history of a previous throat trouble, the comparatively rapid onset, and the absence of lightning pains, will prevent error.

As the diphtheritic paralysis improves, the tendon reflex is regained. Sometimes, however, it does not reappear for some time after what is apparently an otherwise complete recovery.

There have appeared conflicting statements regarding the condition of the tendon reflexes in typhoid fever; some contending that they are normal or somewhat exaggerated, while others state that they are absent in the later stages of the disease. A careful review of the evidence bearing on the subject would point to both of the above statements being true. In the later stages of typhoid fever or even during convalescence, as in the case of diphtheria, neuritis may ensue. It is probably for this reason that the knee jerks are absent late in the disease. It seems to me that the great frequency with which neuritis follows certain infectious diseases, as diphtheria, typhoid fever and small-pox, should lead the practitioner to be on his constant guard for the earliest symptoms of this complication. He cannot, therefore, be too careful in observing the condition of the

tendon reflexes in the above-mentioned disorders. Their disappearance would, at the least, point to a suspicion of oncoming neuritis, thus leading to early precautions, and, perhaps, the saving of a human life.

Alcoholic paralysis, which is also the result of peripheral neuritis, is accompanied by absence of the knee-jerk. The same may be said of arsenical paralysis.

Injuries of the anterior crural nerve will exert the same effect on the knee-jerk as will inflammation of that structure.

The knee-jerk is lost in some cases of diabetes. This is also supposed to be the result of a neuritis. The frequency and significance of absent patellar reflex in diabetics has been variously estimated by different observers. Marie and Guinon found the knee reflex absent in three out of eight cases of diabetes. According to Bouchard, cases presenting this symptom offer a more unfavorable prognosis than those in whom the knee-jerk is preserved. He believes that its absence is noted in the advanced stages of the disorder. Rosenstein, while noting the absence of knee-jerks in many cases of diabetes, does not attach any value to it, either as a diagnostic or as a prognostic sign, considering it simply a sign of innervation, the same as neuralgia, anaesthesia, etc.

While speaking of the condition of the patellar reflex in peripheral nervous disorders, it might be well to note its occasional absence in some so-called cases of sciatica. When such does occur, we are certain that the diseased process is not limited to the sciatic nerve, and that we have more than a simple sciatica to contend with. No amount of disease of that nerve can destroy the integrity of the reflex arc governing the production of the knee-jerk.

In the spinal cord we may have the reflex arc destroyed in the posterior root zones, the postero-lateral columns, and in the anterior cornua. Locomotor ataxia, poliomyelitis anterior, and some cases of myelitis, and softening of the cord are thus associated with destruction of the patellar reflex.

A differentiation of these conditions is not a difficult matter. In the case of an acutely appearing paralysis, without pain or interference with sensation, and atrophy of the affected muscles, the absent knee-jerk would point almost unequivocally to acute poliomyelitis anterior. Were there disturbance of sensation, we would almost as certainly decide that the lesion was in the peripheral nerves themselves. The knee-jerk often remains absent after poliomyelitis, although power over the limb has been in a great measure regained.

This is not at all surprising in view of the very small lesion which may destroy it. Its reappearance in poliomyelitis may always be regarded as of good omen. In several cases of this disease where the phenomenon has returned I have noticed that it has been exaggerated, this exaggeration persisting for some time.

In *tabes dorsalis* or locomotor ataxia the patellar tendon reflex is almost invariably absent. Here the break in the reflex arc is in the posterior root zones. The absence of the knee-jerk is to be noted very early in the course of the disease. In fact, it might be said that by the time that such symptoms as lightning pains, diplopia, and urinary incompetence appear, the integrity of the arc for the production of the knee-jerk has been destroyed. It is now admitted universally that the absence of the knee-jerk may long remain the only symptom of ataxia. That it is not always the first symptom of that disease is shown by Gowers, who had in several cases noticed the disappearance of the movement during the course of the treatment. When once the patellar reflex has disappeared as a result of *tabes*, it is hardly ever regained. So rarely regained is it in fact, that Buzzard expresses as his belief that a case in which such return is reported can be conclusively stated not to have been a case of *tabes* at all.

As is well known, *tabes* is oftentimes ushered in by an attack of diplopia. Inasmuch as tabetic patients often have a syphilitic history, and ocular palsies in the adult are more frequently the result of specific intracranial disease than anything else, it becomes an important question to diagnose the true state of affairs. In the case of an ocular palsy ushering in *tabes*, an examination for the knee-jerk will show it to be absent, while in the case of syphilitic intracranial disease it will be almost as certainly very much exaggerated.

The presence of the knee-jerk does not always exclude *tabes*; in fact, not only may it be retained in rare instances, but it may even be exaggerated. Such exaggeration is always indicative of a complicating sclerosis of the lateral columns. It has been suggested that those cases of *tabes* in which the knee-jerk has returned have later been associated with a sclerosis of the lateral columns. It is worthy of note that those cases of ataxia in which the knee-jerk is preserved are not accompanied, as a rule, with the lightning pains that make that disease so distressing an ailment.

A compression myelitis, a tumor, or softening, or any pathological lesion involving the second lumbar segment of the spinal cord will destroy the patellar tendon reflex.

The knee-jerks are impaired or abolished in certain muscular affections; notably among these may be mentioned pseudo-hypertrophic paralysis, progressive muscular atrophy, and, according to Buzzard, certain cases of Thomsen's disease. In pseudo-hypertrophic paralysis the knee-jerk is not absent at first, but gradually disappears. In progressive muscular atrophy the knee-jerk is in inverse proportion to the degree of atrophy which the quadriceps extensor has undergone. If there is no atrophy of that muscle then the reflex is unimpaired. If there are uninjured fibres, then the reflex will be present though much weakened.

The patellar reflexes are generally lost in meningitis. This is invaluable as enabling us to differentiate this disease from typhoid fever, which, as has already been stated, is associated with either normal or exaggerated tendon reflexes. It was only a few days ago that I was obliged to make use of this very point in the investigation of a case seen with Dr. G. M. Christine. The diagnosis lay between typhoid fever and meningitis, with preponderance of evidence in favor of the latter. The absence of the patellar reflexes served to confirm the suspicion that the latter was correct.

A valuable point to bear in mind regarding the condition of the patellar reflexes in paralysis is that the association of paralysis with absence of these reflexes is conclusive evidence that such paralysis is not functional, but of organic origin.

The absence of the knee-jerk has been noted in a few cases of cerebellar tumor. Such are the exception, however, the rule being to find these phenomena greatly in excess.

Bastian has recently called attention to the fact that in total transverse lesions of the spinal cord the tendon reflexes are abolished, and not excessive, as is commonly believed. The loss of sensibility as well as the loss of motion must be absolute in order to bring about this result. The absence of the reflexes after such severe injuries has been attributed to shock; but that this is not so is shown by the continuance of the symptom even after shock has subsided. The abolition of the reflexes in these cases is attributed by Dr. Bastian to the complete severance from the spinal centres of all cerebellar and cerebral influence.

It now devolves upon me to speak of the exaggeration of the tendon reflexes as a result of disease. When we meet with marked exaggeration of the knee-jerks as a result of organic disease of the spinal cord, we are apt to have at the same time evidence of increased tendon action at the ankle joint, in the shape of the ankle-clonus.



This ankle-clonus is produced as follows: The examiner takes the patient's leg, supporting the heel on his knees, and the popliteal space with the left hand, observing care that the limb is slightly flexed at the knee-joint. Then with the right hand applied to the ball of the foot, that member is pushed suddenly upward, maintaining the foot in dorsal flexion, and putting the tendo-Achilles on a stretch. If the ankle-clonus is present, there appears a rhythmical movement of the foot, which in case the phenomenon is at all well-marked, continues for several minutes or until the pressure is removed. Unlike the patellar reflex, the ankle-clonus is a pathological condition. When at all well-marked I am satisfied that it is evidence of organic disease. When it is present we usually find the knee-jerks very active, though this is not necessarily the case. Two years ago I attended a patient with Dr. Pemberton Dudley, in whose case there was ankle-clonus on both sides, and excessive patellar tendon-reflex on one side and absence on the other. The quadriceps extensor on the side of the absent knee-jerk was greatly atrophied and completely paralyzed. About two years before I saw him the patient had had one testicle removed for sarcoma of that organ. The diagnosis made was tumor of the spinal cord. The patient died, but an autopsy was not obtainable. The most frequent cause of marked ankle-clonus with absent knee-jerk is disseminated sclerosis of the cord.

I have said above, that I considered a *well-marked and persistent* ankle-clonus proof-positive of organic disease. This is not the commonly received opinion. Numerous neurologists of this city consider the presence of such a phenomenon perfectly consistent with hysteria. I have seen now quite a number of cases in which hysteria had been diagnosed notwithstanding the presence of a *persistent* foot-clonus, but the after history of all of them only went to prove that the teaching of Gowers that *persistent foot-clonus is of organic origin*, is strictly correct. The liability to error in these cases is great. Disseminated sclerosis presents a symptomatology bearing a very confusing resemblance, at times, to that of hysteria; one, moreover, that has only recently become understood. All of the cases that I have seen in which hysteria has been incorrectly diagnosed, and in which the ankle-clonus was persistent, have proven to be cases of this disease.

An examination of cases with exaggeration of the knee-jerks reveals the fact that there are marked differences in the manner in which the foot is jerked upwards in several cases. In some, it moves

slowly though through a very large arc; in others, it is quick and sharp, almost as if restrained by the opposing muscles. It seems to me that this particular subject offers a field for future investigation. Althaus is the only author who has reverted to this particular branch of the subject. He refers to three types of increased reflex, two of which he describes. These three are the cerebral, spinal, and muscular. In the cerebral type, the response, he says, is moderately quick and very extensive, so that, taking the patellar tendon-reflex as an example, the leg was thrown a considerable way up with a wide swinging movement, gradually settling down again after a few oscillations. The spinal type is distinguished by a sharp, quick, sudden movement, not nearly so extensive as the former, but is much quicker. Exaggerated reflexes of the spinal type are, according to Althaus, seen in cases of lateral sclerosis, insular sclerosis, and in certain combined system-diseases of the spinal cord. While the above position, assumed by Althaus, is in the main true, it is too sweeping, for there are cases of unquestionable spinal disease in which the cerebral type of reflex is found, and *vice versa*.

The most highly developed knee-jerks and ankle-clonus are found in certain lesions of the spinal cord, notably those affecting the lateral columns. In sclerosis of these fibres, the exaggeration of all the tendon reflexes is typical. They may be obtained at the wrist, elbow, fingers, or, in fact, wherever there is a tendon to tap.

Owing to the location of the inflammation and exudation in pachymeningitis from Pott's disease, the spinal cord-complications of that disease consists of irritation of and pressure upon the lateral columns. Early in the course of the affection, therefore—even before any paralysis has asserted itself—marked exaggeration of the patellar reflexes may be found. Whenever I find a patient with persistent localized spinal pain, with increased tendon reflexes, I at once suspect Pott's disease, a suspicion that I feel is confirmed when the thermometer shows the temperature to be above the normal. The importance of this statement, if true, cannot be overestimated. The effects of a paraplegia from Pott's disease are so serious, and proper treatment if instituted early promises so much, that it would seem unpardonable to allow that stage to go by when cure without deformity is obtainable. The tendon reflex is occasionally absent in the compression myelitis of Pott's disease, but it is only in those cases in which the pathological process attacks the second segment of the lumbar enlargement of the cord.

Some cases of progressive muscular atrophy of spinal origin are

accompanied by excessive reflexes. In such cases we probably have, along with the degeneration of the ganglion cells in the anterior cornua, some sclerosis of the lateral columns.

The knee-jerks are exaggerated in neurasthenia and other functional disorders of the nervous system. This exaggeration is, however, not as marked as that which occurs in organic disease of the lateral columns of the cord. If it is accompanied by an ankle-clonus, the latter is very short lasting, being very different from the strong and persistent clonus of lateral sclerosis, and paraplegia of Pott's disease. According to Buzzard, the exaggerated reflexes of neurasthenia are associated with destruction of the plantar reflex. In fact, he holds that a case of paraplegia with exaggerated knee-jerk and absent plantar reflexes is almost certainly of functional origin. I have no experience to confirm or deny this proposition, though I must confess my inability to understand it. I would not place much dependence upon the absence of the plantar-reflex in persons with calloused soles. In such cases of neurasthenia as I have examined, the superficial reflexes have been found exaggerated. In a case of sexual neurasthenia, or rather hypochondriasis, seen lately with Dr. Van Lennep, all the superficial reflexes were normal with the exception of the cremaster, which was exaggerated. The patient was a man who had unwittingly exposed himself to infection. This caused him a great deal of distress, which haunted him almost constantly. He complained of various vague sensations referred to the genitals.

The condition of the reflexes after cerebral lesions offers a very interesting subject for study. In old cases of cerebral disease the patellar reflexes are exaggerated, the exaggeration being particularly well marked on the side of the hemiplegia. Early in the onset of severe cases of cerebral hæmorrhage, though this is not usually the case, and for a number of hours thereafter, the knee-jerks were absent. Such a symptom is one of great gravity. The condition of the knee-jerks is an invaluable means of differentiating apoplectic-form attacks from those of true apoplexy, in certain cases. As stated above, the hemiplegia of cerebral disease is associated with exaggerated reflexes, especially on the paralyzed side. Apoplectic-form seizures are especially liable to occur in the course of tabes dorsalis, in which case the resulting hemiplegia is associated with absent reflexes. The hemiplegia of apoplectic-form attacks is of much shorter duration than the apoplectic, so that a differentiation is important as a matter of prognosis. The absence of the tendon-reflexes

in some cases of apoplexy is accounted for on the ground that the hæmorrhage produces great irritation of the fibres immediately beneath it; this irritation is transmitted downwards, and exerts an inhibitory influence on the spinal reflex centres. In other cases where the lesion is not so severe, it is merely sufficient to destroy the inhibitory function of the cerebrum, in which case the tendon-reflexes are exaggerated.

Nearly all diseases of the brain cause more or less exaggeration of the knee-jerks. I have met with this exaggeration in lesions of the occipital and frontal lobes, as well as in those of the motor area.

Syphilitic disease of the brain, of all diseases of that organ, is attended with most remarkable increase of tendon reactions. This statement is not of universal application, for cases of specific cerebral lesion will occur in which the knee-jerks are but little more marked than the normal.

In general paralysis of the insane the tendon reflexes are usually increased in the early stages. Should they later become abolished, it is evidence that the degeneration has spread to the spinal cord and involved the posterior columns.

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#### THE NEW OPERATION FOR THE REMOVAL OF THE PILE-BEARING INCH, RE-DESCRIBED AND ILLUSTRATED.

BY E. H. PRATT, M.D., CHICAGO, ILL.

For generations, surgeons have stood in awe of cutting operations about the anus and rectum, because they felt their inability to control the hæmorrhage as in other operative work; hence, they have made use of the *écraseur*, the actual and galvanic cautery, the ligature and other such awkward and distressing measures for the removal of parts demanding amputation. The reason for this weakness of surgeons, who essayed rectal work, was the lack of instruments with which to expose the rectum satisfactorily, and place its tissues wholly under the control of the operator. The invention of the bivalve speculum and the T-forceps has so completely overcome all difficulties in this direction as to completely do away hereafter with all excuse for clumsy and inefficient work in this region of human anatomy.

With the aid of these instruments and ordinary artery forceps, hæmorrhage in any part of the rectum is as completely under control of the surgeon as it is in any other part of the body. Surgical common sense can now have free scope in rectal as in other work. The condition which calls for the new operation is a very common one. Neglected hæmorrhoidal congestions if long continued will give rise

FIG. 1.



Pratt's Bivalve Speculum

to distended veins, areolar tissue, mucous membrane and skin, and induce a permanent hypertrophy of these structures to such an extent that amputation of the entire hæmorrhoidal inch is demanded for the proper smoothing of the surface and the restoration of the patient to a comfortable state. In many cases the diseased mass is constantly protruded from the bowel, occasioning great suffering. In other cases there is merely a prolapse of the tissue at stool, necessitating a

Fig. 2.



Pratt's T-forceps.

replacement each time, more or less painful and difficult. The clamp operation for this condition is not without merit, and will undoubtedly be quite commonly practiced, in spite of all criticism upon it, and all substitutes that may be suggested; but it is not quite satisfactory to all operators; hence the effort to furnish a substitute for it. Whitehead's operation for this condition is ingenious, radical and preferred by a few surgeons. The beginner will find it a little difficult of performance and quite bloody. A little practice, however,

will give the operator more skill and he will soon learn to perform it with more confidence and less hæmorrhage. The operation, which I will now describe, accomplishes the same purpose as the clamp and English operation. It is superior to the clamp, as hand-work is always superior to machine-work, and has so many good points in its favor that it must, in time, become a standard operation. It is less confusing and less bloody than the English, and seems to me its superior in every respect.

*Description.*—The patient is to be placed in a dorsal position, thighs retracted upon abdomen, and buttocks drawn well down to edge of operating table. The rectal bivalve is now to be inserted, and by its aid the rectum is to be thoroughly cleansed, after which the sphincters are to be dilated to the capacity of the valve. This should be done carefully, so as to do as little violence as possible to the mucous membrane. The appearance of the anus will be as in Fig. 3.

Through the diverging blades of the speculum a pair of T-forceps is made to seize the redundant tissue which protrudes between the blades of the speculum, after the manner illustrated in Fig. 4. The speculum is now to be removed and inserted again so as to expose another view of the diseased rim, and another pair of T-forceps is made to grip another mass of the tissue to be removed. Fig. No. 5 is inserted to illustrate this step in the operation. By repeating this process a few times, the entire offending rim is finally grasped by T-forceps seizing it at short intervals, and can easily be rolled out the anus by slight traction upon the forceps placed in the hands of assistants and held in evenly diverging lines, resembling the spokes of a wheel. Fig. 6 illustrates the appearance of the part at this stage of the operation.

Perhaps I should be a little more definite as to the exact position at which the T-forceps are made to seize the mucous membrane. If the mucous membrane of any rectum be carefully examined, the junction of the middle and lower rectum can be seen to be defined by a well-marked line giving the rectal membrane the appearance of being originally constructed of two pieces, which were united along this line. It is not a comely raphe, but looks as though the parts were carelessly puckered in places on the lower side of the seam. Now, in case the subject presents internal piles, there will be irregular protrusions and redundant membrane above this line, and the line of seizure by the forceps must be just above that. If the case be one of merely middle and external hæmorrhoids, the seizure is to be



FIG. 3.



FIG. 4.





FIG. 6.



FIG. 7.







FIG. 9.



FIG. 10.





FIG. 12.



FIG. 13.



made along the line itself. In other words, the membrane is to be grasped along the line of internal amputation, which will be decided by the redundancy of tissue and the position of the hæmorrhoids. While the exposure of the parts is made symmetrical and complete by uniform traction upon the T-forceps in diverging directions, the operator seizes the pair nearest the coccyx with his left hand in such a manner as to leave his index-finger free to locate the situation of the external sphincter, which can easily be felt through the integument while the parts are tense. This sphincter, which can always be felt with the index finger, must be clearly located, as it is an important guide in the operation. A pair of sharp-pointed scissors, curved at the tip, is now needed, with which the mucous membrane is to be completely severed just above the line of seizure by the forceps. If the tissues be well engorged with blood, many arterioles will be enlarged and need seizure by ordinary artery forceps, as they are severed and treated by torsion or ligature, as the operator may prefer. For myself, I have always relied upon torsion, and have had no occasion to regret it. In ordinary cases there will be but three points of hæmorrhage which will require attention. One immediately in front, and the others, one on each side, slightly nearer the front than the back. The forceps are supposed to have but a superficial grip, seizing no deeper than the mucous membrane. When the amputation of the mucous membrane is complete, the upper part has a tendency to withdraw upwards into the middle rectum, and should be allowed to do so as soon as all hæmorrhagic points have been well secured.

Fig. 7 illustrates the appearance of the field of operations at this point in the work; the retracting mucous membrane in the centre, the forceps seizing the part to be removed at the circumference, and the dark rim between them showing the divergence of the severed membrane uncovering the muscular coating of the bowel, the areolar layer between muscle and mucous membrane being so thin and web-like as to furnish but little obstruction to the view of the muscular layer. Without employing the index finger as a guide, as mentioned previously, the muscular coating of the bowel is apt to be mistaken for one of the sphincters; but it need not confuse the operator even in such cases if, as he dissects the hæmorrhoidal mass downward, he exercises care not to destroy any muscular fibre whatsoever. The muscular coat is then but a guide which he can safely follow in his dissection until it be complete at the anus. Where there is considerable tendency to prolapse of the bowel, it is not a mistake to remove a portion of the muscular coat, provided the sphincters be care-

fully located and left uninjured. When the hypertrophied mucous membrane and its hæmorrhoidal attachments have been thus cleanly and completely dissected downwards, uncovering first the muscular layer of the gut and then the sphincters ani, the tissues (with forceps still held in position by the assistant, using gentle traction) will spread widely apart, and present the view illustrated in Fig. 8.

In this view the muscular coat (or what is left of it if it was amputated) has withdrawn upwards and has disappeared in the centre of the field, the external sphincter appearing as a prominent rim surrounding the dark centre, and the offending parts, consisting of redundant membrane and skin, to the inner surface of which are attached all hæmorrhoidal structures, appear about the margin of the wound as a long flap of dissected tissue, completely encircling the anus, and held taut by the forceps seizing the everted margin of the mucous membrane at its line of amputation. This long flap is now to be severed from the body with scissors, care being taken not to cut away too much of the integument. The manner of performing this part of the operation is shown in Fig. 9.

The line of cutting should be so made that the skin remaining should just cover the sphincter muscles, and constitute the exact margin of the new anus. Fig. 10 illustrates the appearance of the parts at this stage of the operation.

In the view, one tenaculum seizes the edge of the skin, and another the previously retracted edge of the mucous membrane. A pair of artery forceps is now to seize the mucous membrane in place of the tenaculum, and as the edge of the membrane is brought to view by gentle traction, it is to be seized at short intervals with T-forceps, after the manner illustrated in Fig. 11, and so on until the entire circumference of the membrane is held in view, and the parts made to present the appearance illustrated in Fig. 12.

Care should be taken not to twist the gut. The mucous membrane is now to be carefully stitched to the integument with catgut, horsehair or silk, as the operator may prefer, the forceps being removed one by one as they become no longer serviceable. When the operation is complete, the parts will present the appearance illustrated in Fig. 13, identical with that obtained with the clamp and English operations.

Retention of urine for a longer or shorter time, necessitating the temporary use of the catheter, is an almost invariable sequence of all these operations, or any operation that involves any amount of stitching of anal tissue. Another symptom is also constant for a time

after all these operations—a spasmodic action of the sphincters at frequent intervals. This can be avoided by severing the sphincters upon one side, while they are exposed, just before applying the stitches which bring the skin and mucous membrane together. This practice is quite satisfactory, as it prevents the painful spasm, and does not appear to hazard subsequent control of the bowel. The stitches should remain for four or five days, and the bowel be moved by an enema a day or so later. The patient should be confined to the bed for about ten days from the day of the operation. Subsequent trimming and dilating are occasionally necessary to complete the work and secure the ideal result of a smooth and dilatable anus. Fig. 14 represents the appearance of the parts after the completion of the operation.

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### A FEW IMPORTANT CHARACTERISTICS.

BY AUG. KORNDORFER, M.D., PHILADELPHIA, PA.

(Read before the Hahnemann Club of Philadelphia.)

ALTHOUGH every true disciple of Hahnemann delights in the fullness of a pathogenesis, he must, nevertheless, recognize the fact that some drugs manifest but few distinctive symptoms, just as some pathological states present but few typical symptoms. Again, it is by no means an uncommon occurrence in disease for a single persistent symptom to appear as it were a centre, around which all the other conditions clustered. These facts have led some investigators to search out such single central symptoms in provings which they may have made, in order thereby to facilitate the selection of the remedy for homœopathic use. Dr. Jacob Jeanes made especial efforts to discover in his own provings such prominent symptoms or conditions, and his success in this fully warrants the reputation for astute observation which he, for so many years, enjoyed. I thought we might profitably employ the time of the Club this evening by considering a few such remedies, instead of treating a single remedy more fully.

Dr. Jeanes gave us : *Amygdalus persica*, a trituration of the kernel of the peach-stone. In this he found especially characteristic : Angina faucium, with soreness and aching pains, but without any characteristics calling for other remedies.

*Anisum stellatum*.—Pain in the region of the third rib, about one

or two inches from the edge of the sternum, generally on the right side.

*Asparagus.* (Preparation of the root).—Pain at the acromion process of the left scapula, also under the clavicle and down the arm, with extreme feebleness of the pulse. This remedy has afforded marked relief in hydrothorax, with feeble heart's action.

*Chenopodium sem.*—Dull pain a little lower down than the inferior angle of the right scapula, but nearer the spine. This symptom has proved characteristic in hepatic and pulmonary affections. *Chelidonium maj.* has a similar symptom below the inferior angle of the right scapula, but involving a larger surface, and often felt as if in the liver.

*Cholos terrapina.*—The provings were made with the second centesimal dilution gtt. ij. in aqua font. f3i. Cramps or cramplike pains in the calves and feet, also in the thighs, or even in the abdomen. Has proved curative in cramps in the calves at night, from various causes. I have also used it successfully in rheumatism, involving the whole body, but characterized by violent cramplike pains in the extremities, the muscles becoming hard and knotty during the intensity of the pains.

*Chimaphila umbellata* was given by Jeanes with benefit in pterygium, and has been recommended in cataract. The itching of the edges of the eyelids and itching of the inside of the lids seem to be characteristic.

*Dolichos pruriens.*—Soreness and tenderness of the gums, even in teething children. Jeanes observed convulsions follow its use in one case during teething, after which he always gave a dose of acornite before administering the dolichos. It has also proved curative in cough on lying down at night; pain as from a splinter near the right tonsil, worse when swallowing. This pain, like a splinter, reminds us of hepar, silic., carbo veg. and nitr. ac.

*Gaultheria.* (Preparation of the berries).—Soreness and jarring from cough, as if in the anterior mediastinum, at times also in the larynx. Cough usually dry, similar to bryonia, but the soreness is less distributed through the chest.

*Ipomea nil.* (Tincture from the seed).—Aching in the small of the back and below; in the lumbar and sacral regions. Rheumatic pains in the extremities, especially in the arms. Has proved curative in the lumbar-pains accompanying uterine and renal affections, as well as in rheumatoid states; also renal colic.

*Juglans cathartica.* (Tincture of the bark from young branches).—

Severe occipital and sub-occipital headache; also has violent pains in the region of the axis vertebra. Dr. B. F. Betts has used the *juglans regia* with marked success in boils, appearing in crops, in the axilla.

*Lobelia coerulia.*—Pain or aching in the posterior aspect of the spleen.

*Mel. cum sale.* (Trituration of honey with salt).—Sore, stiff tender feeling in the hypogastrium. Tenderness in the left side of the abdomen, brought on by twisting or moving the body as if some internal sensitive part were put on the stretch. Pain in the lower part of the abdomen, more perceptible on twisting the body. Sensation as if the bladder might be too full of urine (which, however, was not the case.) Pain from the sacrum toward the pubes. Some of the abdominal pains seem to be in the region of the ureters, causing a suspicion of complication with some trouble of the kidneys. These symptoms have been verified in congestion of the female pelvic viscera.

*Pix liquida.* (Preparation of the Carolina pitch).—Sore pain in the chest, about two inches from the left axilla, on a line with its anterior border.

*Stramonium.* (Tincture of the seeds).—Hip-joint disease of the left side, useful even after pus has developed.

*Ulmus rub.*—Tingling “as if asleep” in the lower extremities; aching pains in the thighs.

*Ustilago mad.*—Hæmatemesis, profuse, blood dark, accompanied by nausea which improves after the vomiting of blood. The potencies used in the provings of these remedies, were usually quite low, though, in practice, Dr. Jeanes used from the third to the one hundredth potency. Most of the higher potencies were run up in water except the last of each remedy, which was made with alcohol from the pharmacy.

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## ABCESS OF MIDDLE EAR, WITH MENINGEAL SYMPTOMS.

BY ALFRED HEATH, F.L.S., M.D., LONDON, ENGLAND.

SOME years ago I was sent for to see a servant girl whom I had recently treated for an abscess which discharged itself down the pharynx, and from which she had quite recovered. I found her in the kitchen quite insensible, with flushed face and slightly delirious.

I immediately gave her, on her tongue, two or three drops of belladonna, 3d decimal dilution, with the result that within one minute she began to cry, but was still quite unconscious. I ordered her to be removed to her bed, and whilst she was being undressed they told me she had been drinking coffee, which was unusual. Knowing what I had recently treated her for, and suspecting that another abscess was forming, and thinking that the coffee might in some way have upset her, I then gave a dose of opium as the antidote to coffee. In what seemed to be only a few seconds she opened her eyes and exclaimed: "How came I in here?" She was put to bed, and I left belladonna to be given to her. She got worse from hour to hour; developed a high state of fever; temperature 104° F., with delirium; at times screaming, at others quite unconscious; when sensible, great dread of any one going near her, and constantly moving her hand around her temple on the left side as if to ward off people, crying out, "Keep away! keep away!" Occasionally she would be quite herself, but always complained of the most excruciating pains, which she described as like a ball of fire in her head. A hospital nurse was always with her. I asked one of the leading London homœopathic physicians to see her. He said she was in a most dangerous condition, and might die at any moment, but that I could not do better than keep on with the belladonna. The following day when I went to see her the nurse said she had had a very sleepless night; *seeming to be heavy with sleep, but unable to*; also wandering; imagined she was up in the ceiling, and wanted to know why they had put her up there. Opium has the sleep conditions, and also produces the symptoms that the *patient imagines he is hovering in the air*. This was the nearest to the mental condition, and I gave a dose of opium, 3d decimal (one only was needful), with the result that she had a long and refreshing sleep, and never afterwards complained of being up in the ceiling. Two mornings after this I found she had again been sleepless all night, and in answer to every question I put to her *she laughed in a very silly manner*. For this condition I gave her one dose of hyoscyamus, 3d decimal. She fell into a sound sleep at once, and all the laughter disappeared. She was still taking the belladonna as a regular medicine. A few days later, when I called I found she had a flushed left cheek. There had been a good deal of neuralgia in the night, and she still had it, and also the terrible pains in her left temple. So I thought I would change the medicine to chamomilla, 3d decimal, and I mixed and gave it at once. When I called in the evening I found she had been *absolutely free from pain of every*



*kind* after taking the medicine, and I went away with a very small idea of myself, thinking that I had been treating a simple case of neuralgia for more than a week, and that there was no abscess after all. Imagine my astonishment the next morning when I was informed that in the early morning the abscess had broken, and that a *torrent* of matter and blood had come down from the head by way of the pharynx, which had almost choked the girl. So that, under the action of chamomilla, 3d decimal, the whole of the frightful pain which had made her insensible and delirious at intervals, *had entirely ceased eighteen hours before the abscess broke*. She made a perfect recovery.

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### FIBROID TUMORS AND THEIR TREATMENT BY THE Milder ELECTRICAL CURRENTS.

BY F. E. CALDWELL, M.D., BROOKLYN, N. Y.

(Read before the Homœopathic Medical Society of Kings County.)

AT the present time there is perhaps no subject that attracts more attention, or elicits more thought from the gynæcologist, than the treatment of fibroid tumors of the uterus.

That they are sometimes successfully treated medicinally is a matter of record, but the process is a slow one at the best, and very often unfavorable circumstances and lack of time render the best efforts in this direction useless.

It is to galvanism we look at the present time as the most successful agent for their permanent relief, and as we grow in knowledge of the wonderful power for good stored away in the various forms of electricity, we may hope to meet with more and more success in the cure of this obstinate difficulty.

The methods of application of the galvanic current are undoubtedly familiar to you all, that of Apostoli being the one most talked of and the most frequently employed. Very powerful currents, varying from 150 to 250 milliamperes are used, often with the needle and puncture and intrauterine electrode. It is my wish in this impromptu paper to invite some discussion upon the strength of the current to be used. Let me put it, then, in this form: Do such heroic doses accomplish the desired result more quickly and with less pain and risk to the patient than a current ranging from 75 to 150 milliamperes? Generally speaking, my own experience has

been, in all applications of electricity, that the same electrical effect may be obtained with a milder current as with a strong one. Powerful currents will occasion more or less pain, and if used at the first treatment will often give rise to so much discomfort as to keep a patient from ever taking the second.

Not many months ago a lady in this city was recommended to come to me for treatment for a "fibroid," but because of one of these very heroic applications, from the effects of which she did not recover for several weeks, she could not be induced to try electricity again. The knife was then the only resort, to which she consented, but with a fatal result. From former experiences I cannot but feel that she might be alive and doing well to-day under the milder current.

Whenever I do use the heroic currents it is only after I thoroughly know my patient and have her entire confidence, and after trying both have often seen a tumor reduced more quickly, and with better results upon the general health, with the lesser current.

Another question is, do we obtain better results by using an intra-uterine platinum electrode or a properly covered cervical electrode? Except in cases of hæmorrhagic fibroids, where I wish to get the cauterizing effect, my own preference is for a round ball electrode, or a cervical electrode smoothly covered with chamois skin. It accomplishes the work just as quickly and without the uncomfortable bearing-down pain that the intrauterine electrode frequently produces.

Of the various cases that I have treated, perhaps these will serve as types:

Miss —, æt. 36, came under my care, suffering from a very large hæmorrhagic fibroid. While in figure she was short and slight, her waist measured  $32\frac{1}{2}$  inches, and she looked like a pregnant woman at full term. Four treatments a week were given with the ball electrode attached to the positive pole and the negative to a large abdominal pad, using a current of 75 milliamperes. She reported as follows:

First treatment, April 5th.

April 19th, measurement  $31\frac{1}{2}$ .

April 26th, measurement  $31\frac{1}{2}$ .

May 9th, measurement 31.

May 15th, measurement  $30\frac{1}{2}$ .

June 1st, measurement 30.

Her general health improved, hæmorrhages ceased, and the tumor was so reduced as to cause no suffering. It could be shaken; it was

so loose. The only unsatisfactory feature in the case was that she could not have remained longer under the treatment.

CASE II.—Miss —, æt. 34, also an enormous hæmorrhagic fibroid. The hæmorrhages at the menstrual periods were so profuse that tampons had to be used, and two years before coming under my care both ovaries had been removed in the hope of stopping the hæmorrhage, but with the result of leaving her as “regular” as she was before. The tumor was so impacted in the pelvis—in fact the uterus itself seemed to be a fibroid—that it was impossible to use the intrauterine electrode, and the ball electrode could only be introduced into the vagina a short way. The treatment was the same as in the former case. It immediately relieved the hæmorrhages, improved her general health—as she was very anæmic—and the tumor was steadily decreasing in size when she, too, was also compelled to leave for her home.

CASE III.—Mrs. —, æt. 48, has had a fibroid for a number of years, and been told by a number of physicians that nothing could be done for her, but at the change of life it would disappear. It however increased all the more at that time. It was an immense tumor impacted firmly in the pelvis and rising well above it. Caused very aggravating constipation and irritation of the bladder, with a marked degree of nervous prostration. She said she felt all the time as she did in the last days of her first pregnancy. The ball electrode was also used in this case in the posterior cul-de-sac, with a very large external pad, positive internally, negative externally, with a current of 100 milliamperes for seventeen minutes, applied three times a week.

She improved in general health from the first treatment, and in three months' time the tumor was so reduced as to relieve the bladder irritation and constipation and to cause a marked difference in her size, the tumor being easily shaken now in the abdomen. After a rest of a few weeks she is again under my care, and I hope to be able to carry the case on to a result that will be satisfactory, not only to the patient, but to myself from a professional point of view.

Let me say in conclusion, that Cases I. and II., since their return to their respective homes, have done finely, and from a large experience my positive opinion is, that the galvanic current, when properly applied, will in a large per cent. of cases reduce the tumor to a large degree, and at the same time destroy its vitality. Will restore the patient's general health, and allow her to live out her allotted time in comfort and happiness.

**HYDRASTININ FOR UTERINE HÆMORRHAGE—DR. EDMUND FALK.**

(Translated from the *Archiv. für Gynäkologie*, p. 286, Heft 2, 1890, by G. R. Southwick, M.D.)

HYDRASTIN ( $C_{21}H_{21}NO_6$ ) is resolved by oxidation into a base, hydrastinin, and into an acid, opianic acid. The new base, hydrastinin, has the formula  $C_{11}H_{13}NO_3$ , is perfectly white in the pure state, melts at  $116^{\circ}$ – $117^{\circ}$ . (The writer does not state the scale) and contains a molecule of water of crystallization so firmly bound that it is not lost in recrystallization from non-aqueous solutions. Hydrastinin is very soluble in alcohol, ether and chloroform. It is dissolved with more difficulty in warm water and with most acids forms a salt easily soluble in water. The hydrochloric acid salt is colored light yellow, dissolves easily in water and the solution shows a light fluorescence.

In cold-blooded animals, we can differentiate two stages in the action of hydrastin. In the former, from irritation of the spinal cord, there is an increase of the reflexes, which may lead to severe tetanic convulsions. In large doses, the second stage is quickly reached, that of complete paralysis. In hydrastinin, on the contrary, the irritation of the spinal cord is wanting; it causes a paralysis depending for its effect on the motor sphere of the spinal cord, although the dose of hydrastinin must be twenty times greater than hydrastin to cause poisoning.

Hydrastin has also a local effect. At the site of injection the extremity becomes hard as a board, there is extreme rigidity of the muscle. Reflexes are not excited in the neighborhood of the site of injection; nerves and muscles lose their electrical excitability. Hydrastinin shows no such injurious effects, neither in the warm-blooded animals nor in the cold-blooded, nor is there any local effect after subcutaneous injections.

The different action on the heart between hydrastin and hydrastinin is quite remarkable. Hydrastin is a marked cardiac poison; it causes arrest of the heart's action in the diastole, probably from a paralysis of the automatic centre. The inhibitory ganglia are early paralyzed; accordingly with small doses, acceleration of the pulse precedes retarding of the heart's action. Hydrastinin, on the other hand, is not a cardiac poison; it rather excites the heart, as we observe after placing the isolated frog's heart in Williams's apparatus, a sinking of the blood-pressure from hydrastin and an increase of blood-pressure after hydrastinin.

We also find in warm-blooded animals a paralytic effect on the motor centre and an action on the reflex ganglia in the spinal cord, which kills the animal from tetanic convulsions, either spontaneous or is caused by repeated peripheral irritation.

Hydrastinin shows, as the most important symptom of poisoning, a pure central paralysis, causing death from its effect on the respiratory centre.

Hydrastin would cause an increase of blood-pressure of 10–20 mm., but never raising the original pressure more than 30 mm., while the increase of blood-pressure from hydrastinin was never less than 50 mm., and sometimes reached 80 to 100 mm. This increase of pressure was clearly due to contraction of the bloodvessels.

With hydrastin, the increased blood-pressure stops far below the original position and the vascular system shows marked relaxation. According to Fellner's investigations the fluid extract of *hydrastis canadensis* has a similar effect, *i.e.*, in rabbits it causes marked variation of blood-pressure, marked depression followed by high increase, extreme retardation of the heart's action, arrest of the heart and irregularity in rhythm. Nothing of the kind takes place with hydrastinin; the increase of blood-pressure remains moderately high, and the contraction of the vessels continuous and even. In the abdominal organs the contraction of the bloodvessels is so marked, that during the action of the hydrastinin, the secretion of urine is diminished and with the highest degree of blood-pressure there is complete anuria in consequence of too small an amount of urine circulating through the kidneys.

In large doses we see with both hydrastin and hydrastinin a gradual sinking of blood-pressure before death, but with hydrastin the lowered blood-pressure cannot be raised by artificial respiration, a sign that the relaxation of the vessels is an immediate consequence of the action of hydrastin; on the contrary with hydrastinin the diminished blood-pressure can always be raised over the normal by ventilation. The vascular system itself therefore shows no relaxation just before death; the sinking of blood-pressure is a secondary phenomena, due to cessation of respiration.

These various conditions explain that hydrastin acts on the vaso-motor centre, while hydrastinin acts especially on the vessels themselves as experiments after paralyzing the vaso-motor centres by chloral hydrate prove; in these cases hydrastinin causes increase of blood-pressure which does not follow hydrastin after paralyzing the centre. Finally we observed that in hydrastinin death could be

averted by artificial respiration, while with hydrastin the blood-pressure is not increased and that in spite of artificial ventilation, the heart will cease to beat, a proof that hydrastin in warm-blooded animals, as well, is a heart poison in contradistinction to hydrastinin.

It is obvious that the stronger and longer vascular contraction caused by hydrastinin makes it a far better remedy for hæmorrhage than hydrastin; besides, it has no injurious effect upon the tissues. The following cases, treated with hydrastinin, are reported from the clinic of Dr. Landau:

### I. HÆMORRHAGE WITHOUT LOCAL DISEASE.

#### *A. Congestive Dysmenorrhœa.*

CASE 1.—A. G., 18 years old, menstruated for the first time in her fifteenth year. Flows always six to eight days; suffers from severe congestive symptoms. Uterus small, movable, appendages free, ovaria duplex, no heart disease. Five days before the expected menstruation, the patient was given daily an injection of 0.05 hydrastini muriatici, and during menstruation, each day, 0.08–0.1. The period lasted three and one-half days. The patient lost much less blood than usual, and suffered no inconvenience. The following period also lasted three days with no complaints.

CASE 2.—L. L., æt. 17. Menstruation very profuse for the past year, lasting six or eight days; with it large blood-clots were passed, accompanied by severe pain. Frequent attacks of faintness and dizziness; pale, bloodless appearance; normal condition of the genitals. The menstruation diminished with the use of hydrastinin. After the first injection the patient became faint, and complained two hours later of persistent cramping pain in the abdomen.

CASE 3.—B. G., æt. 35, *duipara*. Periods always very profuse, lasting eight or ten days; clots on the second day the size of walnuts; always congestive dysmenorrhœic symptoms. Tincture of ergot used without any success. Pendulous abdomen; uterus small, in a normal position, movable; erosion of the cervix, leucorrhœa. Injections were commenced five days before menstruation. The flow lasted five and a half days, during which the patient lost much less blood than usual; no clots, no prostration afterward, as was formerly always felt. No complaints of a congestive character. Some hours after the injection there were crampy pains in the abdomen. Patient felt the sensation of being laced, and the pains were labor-like. The second menstruation lasted six days, with hydrastinin treatment of less amount than the preceding period. The same was true of the third menstrual period, in which no hydrastinin was employed, and lasted six days. The fourth menstruation began profusely, but became scanty after three injections and ceased on the fifth day. Otherwise the patient felt well.

*B. Hæmorrhage from a Virgin Uterus.*

CASE 4.—T. J., æt. 28, unmarried. Menstruation profuse and irregular since her twelfth year. Periods frequently attended by pains in the sacrum and abdomen. For the past year she has had two uterine hæmorrhages a month, lasting from eight to twelve days. In September there were only six days in which there was no bleeding. No heart disease. Slight retroversion, otherwise normal physical conditions. Last menstruation lasted from the 17th of September to the 1st of October. The patient was given an injection of 0.05 every second day after the 3d of October. The next menstruation began on the 26th of October, and lasted three days without any complaint. During it she was given daily an injection of 0.1. The treatment was continued, and the next period appeared on the 1st of December, and continued, rather scanty, till the 4th. From this time on, the menstrual periods became regular and scanty without the use of hydrastinin. Besides several infiltrations or knots in the subcutaneous tissue, there were some spots looking like bruises, the size of a quarter of a dollar, which disappeared in two or three days.

*C. Essential Hæmorrhages.*

CASE 5.—Mrs. K., æt. 28, childless. For five years very profuse menstruation, lasting six or seven days, with clots. Menstruation returns every twenty-one days, accompanied by sacral pain and lassitude. She had been treated unsuccessfully for some months with ergotin. No improvement after curetting the uterus. Genitals normal. After injections, the two following menstruations were from four to five days each; the first period was more scanty than the second. After the injections there occurred, a few times, a slight discharge of blood.

CASE 6.—E. B., æt. 24, primipara. The menstrual periods have been very profuse for five months, and return once in two or three weeks. The first time, the period lasted eight days; the last period the patient flowed fourteen days and passed large clots of blood. She complained of faintness and great lassitude during and after the period. The uterus is small, sharply antiflexed, movable, appendages free. The three following menstruations returned, six, four and a half, and four and a half weeks apart, respectively, lasting from seven to nine days, with much less flow than formerly and less prostration. The menstruation again became very profuse, after discontinuing the injections. After the injections there were labor-like pains, and, sometimes a bloody discharge for a short time.

## II. HÆMORRHAGES CAUSED BY PATHOLOGICAL CHANGES IN THE UTERUS.

CASE 7.—Mrs. L., æt. 37, has had five children and seven abortions. After an abortion in the sixth week there was an offensive, dark discharge; four weeks later hæmorrhage with clots. This

lasted eighteen days, and has been very profuse for the last few days. The hæmorrhage ceased completely after two injections of 0.1 hydrastinin.

CASE 8.—H. E., æt. 18. Irregular since her thirteenth year, usually menstruating too early. Has flowed nine days once in fourteen days for nine weeks. Ergotin used without success. Patient came for treatment on the fifth day of a very profuse menstruation. The hæmorrhage ceased after the first injection of 0.1 hydrastinin. While the patient had felt weak after the injections of ergotin, and complained of pain at the site of the injection, no such symptoms were experienced after the injection of hydrastinin. She was given two or three injections a week of 0.05 hydrastinin, and 0.1 daily during menstruation. The following periods occurred three or four weeks apart, lasted five days, were weak, and without lassitude or intermenstrual hæmorrhages.

CASE 9.—C. H., æt. 29. The menstruation has been very profuse, lasting six days for eleven years. Lately she has been irregular, and the periods appear once in two weeks. After injections of hydrastinin the menstruation became regular, scanty, fluid, and the patient feels better.

CASE 10.—K., æt. 38; had four children. Since an abortion, three years previous, the patient has complained of sacral and abdominal pains. The periods became irregular, every twenty-four days, and lasted eight days. Curetting and ergotin used unsuccessfully. The vaginal portion is missing. There is metritis and endometritis. In spite of regular treatment there was no special effect on the flowing, though other complaints improved.

CASE 11.—L., æt. 26. Metritis and endometritis followed a premature labor, fifteen months previously. This made the menstruation profuse and painful, every two or three weeks, lasting eight days. Curetting without success. After injections of hydrastinin the menstruation became regular, lasted a shorter time, three to six days, much less flowing and pain. The periods continued regular without the hydrastinin.

CASE 12.—B., æt. 33. In consequence of metritis and endometritis the menstruation has been very profuse for two years, lasting eight days, and in the intermenstrual period there is almost always bloody leucorrhœa, sacral and abdominal pains, which are so severe during menstruation as to confine her in bed. She was treated five weeks with hydrastinin (twenty-three injections) without any effect on the hæmorrhage, but the bloody leucorrhœa became more scanty. Marked improvement followed curetting the uterus and using hydrastinin.

CASE 13, æt. 40.—For six months, in consequence of endometritis, the menses have appeared every three weeks, very profuse, clotted, lasting seven days, accompanied by pain in sacrum and head, sleeplessness and much prostration. Intermenstrual bleedings were of common occurrence. After regular treatment the period returned in four weeks, lasting three and one-half days, fluid and much re-



lief of all the symptoms. After cessation of treatment the following periods appeared once in twenty-four days, lasted three to four days, were scanty, painless and there were no intermenstrual bleedings. After the injections the patient sometimes had a little flowing, lasting for a couple of hours.

CASE 14, æt. 25.—Had three children and one abortion. Endometritis followed a labor, two years previous; since then the menstruation has been very profuse, lasting nine days; there is also regularly one or two days of intermenstrual flowing. The finger enters the cervical canal as far as the os internum. The uterus is 10 c.m. deep; bleeding after the use of the sound (endometritis, metritis). Under hydrastinin treatment the first menstruation did not occur for nearly five weeks, lasted six days, is much more scanty than formerly, and the patient does not feel so weak as before. The following periods returned once in four weeks, lasted six days, and were much more scanty than formerly. There were no more intermenstrual hæmorrhages. After eight weeks of treatment the uterus is 8 c.m. deep, the endometrium is less sensitive and does not bleed.

CASE 15.—K. N., æt. 22. The menstruation became very profuse after an abortion, a year previous; lasts fourteen days; flow clotted, severe pain in the sacrum and abdomen. After injections the menstruation became scanty, painless and lasted four days.

### III. HÆMORRHAGES CAUSED BY PARAMETRITIS, PYOSALPINX, ETC.

CASE 16.—E. D., æt. 22.—Neurasthenic. For two years there have been hæmorrhages every eight to fourteen days, which sometimes pass uninterrupted into one another. The patient flows at least fourteen days each month. Laparotomy was performed and the left ovary removed in July, 1887, on account of the hæmorrhages. Repeated curetting and use of tincture of ergot without success. The patient has flowed for three weeks, and very profuse for four days. There is a small fibroid on the anterior vaginal wall; uterus small, movable. In the right broad ligament there is a tumor (hydrosalpinx) about the size of a hen's egg, which is scarcely movable. The hæmorrhage ceased after three injections, but the patient complained of nausea and vomiting. Although the patient flowed but a few days in the next three weeks, she felt no improvement, and the treatment was discontinued. Curetting was also unsuccessful.

CASE 17, æt. 25.—She complains, for a year, since a normal labor, of pain in the left side of the abdomen, and a drawing downward. The menses have become more profuse, appear every two or three weeks, continue eight or ten days; once, for three weeks, so that the patient flowed uninterruptedly and was very weak. Curetting without success. Uterus retroflexed; hydrosalpinx dextra; pyosalpinx sinistra. Hydrastinin injections begun during menstruation, gave no relief. Afterward, she received two or three in-

jections a week, 0.05 of hydrastinin. The periods then became regular, much more scanty and lasted six days. There were frequently labor-like pains after the hypodermic injections; sometimes there was a slight flow of blood.

CASE 18, æt. 39.—A very severe hæmorrhage at the commencement of an acute pyosalpinx was at once arrested, after an injection of 0.1.

CASE 19, æt. 25.—Has flowed irregularly for fourteen days, and of late very profusely. Uterus small, displaced backward; on the left side, extending to the pelvic wall, there is an exudation, the size of a hen's egg. The ovary is enlarged, the tube thickened and surrounded by an exudation. The hæmorrhage lessened and entirely ceased after the second injection of 0.1 of hydrastinin.

#### IV. MYOMAS. (FIBROIDS.)

CASE 20, æt. 36.—For the past year, menses once in three weeks; last eight to twelve days; clotted. The patient has flowed uninterruptedly for four weeks; complains of colicky pains in the abdomen; urging to urinate; drawing pains in the right limb. Intraparietal fibroid on the posterior wall, the size of a walnut. The bleeding became weaker and ceased entirely after five injections. The next period lasted five days and was less than formerly.

CASE 21, æt. 36.—Uterus forced to the left; to the right of it and posterior is a tumor (fibroid) in connection with the uterus, immovable and lying in the broad ligament. Besides the profuse menstruation, there are irregular hæmorrhages, usually a four days' intermenstrual bleeding. She was treated unsuccessfully with ergotin. The intermenstrual hæmorrhages ceased after the regular use of injections; the menstruation became regular, much more scanty and weakened the patient much less than formerly.

CASE 22, æt. 39.—Multiple myoma (fibroid) in the wall of the uterus, the size of a child's head. Tumors (fibroids), the size of a fist, extend into both broad ligaments. Menorrhagias, besides irregular hæmorrhages. After two injections of 0.1 of hydrastinin, used during the bleeding, the hæmorrhage ceased.

CASE 23, æt. 49.—For seven years, sacral pains and menorrhagia. Had been treated with ergotin three months and a half, without success. She had an abscess develop in the abdominal wall, but the hæmorrhage did not diminish. Recently, menstruation has become irregular; lasts fourteen days, after which the patient feels very much prostrated. There are two tumors, distinctly separable from one another; on the right is one, immovable, round, about the size of a child's head, with a broad base attached to the lower and posterior segment of the uterus. The uterus, with the second tumor, extends to a finger's breadth below the navel. The largest transverse diameter is nineteen and a half centimetres. The menstruation was lessened by hydrastinin injections, lasting four days, and the patient does not feel as weak.

CASE 24, æt. 43.—A beginning intramural fibroid in aretroflexed uterus. Menstruation very profuse, lasting thirteen days, with severe sacral pains; lately, menses appear every three weeks. After the use of hydrastinin, the following menstruation appeared, after four to four and a half weeks, was very much less, and only lasted five days. Labor-like pains after the injections.

CASE 25, æt. 45.—Menorrhagia, in consequence of an interstitial fibroid. A hæmorrhage, which had lasted sixteen days ceased after an injection of 0.1 of hydrastinini mur. With continuous treatment the next period did not appear for six weeks; was of shorter duration and more scanty than formerly.

CASE 26, æt. 37.—Nullipara. A small, intraparietal fibroid causes frequent, irregular hæmorrhages; flowing for eight weeks scarcely interrupted, which was lessened after curetting, but did not cease. It was entirely arrested by an injection of hydrastinin.

CASE 27, æt. 49.—Had fourteen children. Last labor five years ago. Since then, the periods have been very profuse, lasting eight to fourteen days. Uterus large; walls concentrically thickened; fibroid, the size of a walnut, in the posterior lower wall. The periods became very much weaker, after injections of hydrastinin, and lasted from three to six days.

CASE 28, æt. 45.—Very profuse menstruation for twenty-one years. In recent years, the patient has flowed irregularly for fifteen to twenty days, every month. Curetting was employed, without effect. There had been very profuse bleeding for three weeks, when the patient came for treatment, having a pale, bloodless appearance, and complaining of sacral pains. A hard tumor, the size of a child's head, of uniform density, occupied Douglas's *cul-de-sac*. The hæmorrhage ceased after four injections, but the sacral pains continued undiminished. The next period did not occur till five weeks after the cessation of the last menstruation, and was quite profuse.

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Women who have not borne children, state that it seems as if the abdomen were laced together, while women who have suffered labor-pains, emphasize this character of the pains. This contracted condition of the uterus lasts usually several hours, and women often have a slight, transitory discharge of blood, after using the injection, which often occurs in the evening, if the injection was given in the morning. I can only explain it in this way; that it is due to the return of the uterus to its ordinary relaxed condition, after the contraction due to the hydrastinin has subsided.

I usually employ a 10 per cent. aqueous solution of hydrastinin, which will keep good for some months, and inject half or a whole hypodermic syringe full, i.e., 0.05 to 0.1 of hydrastinini mur., and for uterine fibroids and menorrhagias 0.05, twice a week, in the intermenstrual periods, daily six days before the period, and 0.1 during the flowing. I have seen no bad results from it.

## A CASE TREATED BY SKIN-GRAFTING.

BY M. J. BUCK, M.D., BALTIMORE, M.D.

THE following case is reported as illustrating the results that may be obtained from the application of skin-grafting after the method I described in the *HAHNEMANNIAN MONTHLY* for March, 1890 :

Mr. —, æt. 18 years, was bitten, in the summer of 1887, by a vicious horse, over the right deltoid region. Erysipelas followed the injury, and this in its turn by sloughing of the skin from the point of the acromion process to within two inches of the radio-carpal joint. The only portion of the skin that escaped was a small island about four inches in length and two in width over the olecranon process. It was certainly the most extensive denudation I have ever seen. The patient was more or less nervous, constantly waking up in violent delirium. On my first visit I gave him arsenicum 30. On my return two days later I found him somewhat improved, though still delirious on waking. I then gave lachesis 200, and on my next visit was gratified to learn that his slumbers were more peaceful and his waking more placid. I dressed the arm at each visit with oiled silk, and over this applied a roller bandage with moderately firm pressure, taking care to remove with scissors any portion of necrosed tissue before applying the dressing. After one week's treatment it became evident that healing under a year's time was out of the question, unless skin-grafting was resorted to. The arm was prepared for the operation by enveloping it in lint, steeped in hot water and wrung out as dry as possible, and covered by wax paper. This dressing was permitted to remain for twelve hours. I then applied sixty grafts taken from the skin over the biceps muscle of the healthy arm, following the plan referred to in my article in the March number of this journal. On removing the bandage on the sixth day, I was gratified to find that over half the grafts had taken, around which granulation was proceeding rapidly. At the end of ten days I repeated the setting-out process, putting out fifty grafts, of which but twenty "took." By this time I had over fifty points, at which healing was rapidly taking place. At the end of three months I had, with the assistance of nature, succeeded in healing up a wound that would certainly have taken as many years, if it had healed at all, by the other methods.

The points upon which I insist as important in the application of skin-grafting are: The proper preparation of the surface, the making of the grafts almost infinitesimal in size, the pricking of the denuded surface with a fine-pointed tenotome, drawing a drop of blood, and

pressing the graft into the puncture thus made; the retention of the graft by firm pressure, the removal of the dressing not oftener than once in five days, and the cleansing of the surface by carefully pressing it with absorbent cotton, thus removing the pus; and the application over each graft of a small piece of oiled silk in order to prevent it from adhering to the dressing.

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THE USE AND ABUSE OF SOAP AND WATER.—B. Merrill Ricketts, M.D., calls attention to a reddened condition of the skin of the face, accompanied by considerable burning, particularly from exposure to draughts of wind. At other times quite painful sensations are experienced. It never occurs upon any other portion of the body, and always affects those who are fastidious in cleanliness, or in women who use cosmetics too frequently and wash themselves too often, many times drying the skin by brisk rubbing with a coarse towel.

His treatment for the affection is abstinence from the use of water. Dirt is to be removed by olive oil, which is to be rubbed off with some soft linen or silk. Where cosmetics and too frequent washing have produced the disease, he recommends that no cosmetics be used, and that olive oil, to which a few drops of carbolic acid have been added, be employed for cleansing. Following its use, rice powder should be liberally dusted on the face. These measures will result in relieving the unpleasant sensations, and restore the skin to a smooth, soft, not desquamating condition.

There are a number of plants,—among them the soap-berry tree, belonging to the genus *Sapindus* and the *Phalangerium pomaridianum*, of California,—the juice of which, when rubbed with water upon fabrics, makes lather which answers the purpose of soap. Saponine, as the substance is called which produces this lather, is closely allied to the glucosides, and is found in the soap-wort, the pimpernel, the root of the pink, and in many other plants.

Soap is the result of a union of one or more acids obtained from fatty bodies with alkalies or oxides, the process consisting in a substitution of the alkali for the radicle of glycerine, the latter combining with the elements of the water to form glycerine. Soft soap is made with potash; hard soap with soda.

In the soft soap, which is principally made with olive oil, we find an excess of potash, which causes it to be of a brownish-yellow color and viscid. Potash is a much stronger alkali than soda, for which reason the soft soap should not be used for toilet purposes. It is also prepared from animal fats, such as the oil obtained from the seal, whale, walrus, manatee, and the aquatic animals in general. The fact that there are more or less iodine and bromine found in these oils is evidence that they should not be used upon the human skin, either pure or converted into soap.

Most vegetable oils combined with carbonate of soda will make hard soap. Coconut and palm oil soaps give much lather, but they contain properties conducive to rancidity. The ordinary white Castile soap is made from olive oil and soda; the green variety is colored by the addition of green vitriol, which fact should be sufficient evidence to condemn its use.

The chief adulterants of soap are lime, gypsum, heavy spar, stearate and pipe-clay, while in the Spanish soaps glue is frequently found; all of which can be detected by dissolving the soap in water, when precipitation of these substances will result. One hundred parts of pure soap, dissolved in alcohol, should not have more than three parts of insoluble matter, and at least two of these parts should be soluble in water.

The author, with the aid of Prof. Karl Langenbeck, has made what might be termed a saponaceous cream, which contains neither an excess of acid or alkali. After chemically testing olive oil and soda, water is added, the result being a saponification into a smooth, gelatinous, opaque, odorless and neutral mass, which gives but little lather when used with water. To this is added fresh egg-albumen, thoroughly incorporated by means of an ordinary egg-beater; a few drops of oil of roses, bergamot or bitter almonds being added to give it an agreeable odor.—*Journ. of Cut. and Gen.-Ur. Dis.*, May, 1890.

## EDITORIAL.

## A BAD CASE OF CHEEK.

WOULD that we possessed a facile pen, that flowing ink could depict our feelings, as we carefully perused the *Therapeutic Gazette*, for May, 1890, and found therein a paper on the "Therapeutic Uses of Sulphide of Calcium," by Dr. John Aulde, of Philadelphia. We have, on former occasions, taken the opportunity to express very plainly our opinions of Dr. Aulde's discoveries regarding the beneficent action of rhus and arsenite of copper in disease. But to give expression to our feelings on reading this, his last communication, we find language inadequate. Dr. Aulde informs us in the very first words of his paper, that

"Within the past two years I have read with interest many suggestions covering the treatment of boils and carbuncles." . . . "The object of the present paper is more for the purpose of calling the attention of the general practitioner to a plan which has been followed with very satisfactory results *during the last five or six years*," \* etc.

Then follows a review of the theory concerning the microbic origin of suppurative diseases; our author naively remarks:

"If microbes are present in their incipiency, their rapid absorption or destruction may be favored by the judicious use of calcium sulphide."

Dr. Aulde then proceeds to describe his method of treating suppurating diseases, consisting of the use of certain antiseptic measures locally, and the internal use of hepar sulphur 1x; no, we mean sulphide of calcium, in doses of one-tenth of a grain, given every hour or two. The only intimation that we have as to the source from which Dr. Aulde obtained his information concerning the drug in question, is contained in the following paragraph or, rather, sentence:

"I am in a position which enables me to confirm all that has been said of the therapeutical value of calcium sulphide by Dr.

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\* Italics ours.—Eds.

Mortimer Wilson, of Port Huron, Michigan (*Therapeutic Gazette*, p. 306, 1888) in the treatment of boils, abscesses, pustular acne, and leucorrhœa, and *desire to add to the list a number of other diseases which are not infrequently rebellious to the ordinary methods of treatment.*"\*

The treatment of paronychia next receives his attention, and thus does he discourse :

"I most strenuously object to all palliative remedies which have for their object the breaking down of tissues, with a view to favor suppuration. Turpentine, carbolic acid, iodine, nitrate of silver and other caustics and escharotics must be abandoned when it is shown that their use does more harm than good." . . . "The continuous exhibition of calcium sulphide, as heretofore indicated, will shortly reduce the activity of the inflammation, and when seen early, few cases will go on to suppuration, while the demand for anodynes and poultices is wholly eliminated from our treatment," etc.

Now comes an admission :

"I do not claim priority in the use of the drug, although during the past few years several papers from my pen have appeared upon the subject. Possibly, I may be entitled to some credit for extending the usefulness of the drug, by finding some new applications for it, and for calling attention to these, and to the more general uses, as originally recommended by Dr. Sydney Ringer, of London."

No homœopathic physician would allow Dr. Aulde a claim for priority in the use of the drug, even though he saw fit to make such claim, nor will he admit that individual's right to claim priority or rather "credit" for extending the usefulness of the drug, after learning of the conditions to which it has been newly (?) applied. Here they are :

"In the treatment of ovarian and uterine affections, calcium sulphide often serves a double purpose by preventing the formation of pus. . . . "Not infrequently, displacements of the uterus are attended with ovarian pain, which, if not given attention, result in salpingitis and a long train of ills, that are only relieved after years of suffering by resort to the knife. I have been fortunate in quite a number of instances in overcoming this chronic ailment by suitable local treatment and the exhibition of calcium sulphide in doses of one-tenth of a grain at intervals, so that five

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\* Italics ours.—Eds.

tablet triturates, each containing this amount of the drug, are taken daily."

So Dr. Aulde uses tablet triturates, but inasmuch as allopathic druggists are now engaged in the manufacture of these preparations, it is not necessary that he should have purchased them at a homœopathic pharmacy. But let us hear something as to the other diseases to which the usefulness of calcium sulphide has been extended.

"Bronchial catarrh, acute, subacute or chronic, is always benefited by the use of calcium sulphide." . . . "By a rough estimate I should judge that two-thirds of all the coughs and colds might be treated thus, and with much better results than by the administration of such nauseating mixtures as are concocted by the old-fashioned practitioners." . . . "Croup is quickly amenable to this method of treatment (calcium sulphide), and when begun early and used faithfully, there will be less likelihood of intubation being demanded. In the case of toothache and earache, and in fact in all diseases in which suppuration is threatened, calcium sulphide produces results that are, to say the least, remarkable."

The above-named affections are the ones to which Dr. Aulde has extended the usefulness of hepar sulphur, *alias* calcium sulphide. Can our readers fail to be amused at the cheek of such a claim? Credit, indeed, for such discoveries! At the time when Dr. Aulde was playing with his toys, homœopathic physicians in this country and elsewhere were employing hepar sulphur, or, as he is pleased to call it, calcium sulphide—a rose by any other name would smell as sweet—in the treatment of paronychia, ovarian and uterine affections with suppuration, bronchial catarrh, croup, toothache, earache, and hosts of other affections, concerning which he will learn the applicability of the drug in the near or remote future.

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#### MEDICINE VS. POLITICS.

WE have read with pleasure a reprint from the editorial pages of the *New England Medical Gazette* bearing the above-named title. Our esteemed contemporary has always taken a very lively interest in all things pertaining to the welfare of the American Institute of Homœopathy; so we consider its utterances on this subject of vital importance. We will agree most cordially with our contemporary, that the mingling of political with scientific methods at our national



meetings is an evil requiring correction. Still it is far easier to point out the faults of existing methods than to formulate remedies. A certain amount of electioneering is not only necessary but healthful; it is only when the electioneering is carried to excess, and this is now the case, that it becomes an evil. The nominating speeches with which candidates are introduced on the floor of the Institute are not of the slightest use to the Institute as a body. We most cordially endorse the proposition already made to the Institute, that these be done away with entirely.

Some time ago the *HAHNEMANNIAN MONTHLY* offered the suggestion that the nominations be made by a nominating committee, said committee to consist of one member from each State represented in the attendance at the session. The advantage to be derived from this method is that the committee could discuss quietly the merits of various candidates, and report the results of their deliberations to the Institute in the shape of nominations. Their report would not be liable to the objection of having been animated by sectional favoritism. The great objection to this plan is that the committee must be appointed by the President, and it *could* (not necessarily *would*) give him the power of naming his successor. As this plan has worked well in other large associations, we see no reason why it should not work well in the Institute.

The plan that has been in use by the Massachusetts State Society for years is worthy of careful consideration. It was the duty of the Executive Committee of the Society to nominate and send to each member of the Society a list of two persons for each office. "The ballot box is then kept open the larger part of the session, so that each member in attendance can prepare and quietly deposit his ballot when convenient." This plan we are told worked admirably, and the society prospered, its meetings having been free from political methods. Dissatisfaction among some of the members, however, led, at the last annual meeting, to the adoption of another plan, which we shall shortly describe. We must confess that we like the old plan of conducting the elections in the Massachusetts Society. It does away with nominating speeches, and, if adopted by the Institute, would save two or three hours of valuable time which could be devoted to the scientific work and general business of the session.

The following are the new by-laws governing elections of officers in the Massachusetts Homœopathic Medical Society:

SECTION 1. The Secretary shall prepare and send to all members,

with the notice of the annual meeting, an official ballot with the names of candidates, as follows:

- a. The names of the existing officers marked with a \*.
- b. The name of a candidate for each office, selected by the executive committee, marked with a †.
- c. The name of a candidate for each office, provided such may have been selected at a caucus of members, and certified to by at least ten members, who were present at said caucus, and who approved of said candidates, marked with a ‡.
- d. The names of candidates for each office shall be arranged in alphabetical order.
- e. When the same person is nominated for an office by more than one authority, the name need not be repeated, but the \*, †, or ‡ may be placed before the name to indicate the source of nomination. If any candidate decline the nomination, previously to the printing of the ballot, it shall be so indicated on the ballot.

SEC. 2. The caucus must be held and the names of the candidates thus selected must be placed in the hands of the Secretary, at least one month before the time of the annual meeting.

SEC. 3. Members shall prepare their ballots by making the sign X against the name of the person for whom they desire to vote. If more names are thus marked upon any ballot than there are officers to be elected, the ballot shall not be counted as regards the office for which such excess is marked. This shall not, however, invalidate the ballot for the other offices.

SEC. 4. Ballots must be deposited in the ballot box by members in person, and a check-list shall be kept of all members who vote. Those votes only will be received and counted which are prepared in the official manner herein provided for.

SEC. 5. The notice of the annual meeting shall specify the time during which the ballot box shall be kept open, which shall be at least three hours on the day of the annual meeting.

SEC. 6. The persons receiving the highest number of votes shall be declared elected to the respective offices.

The objections we would offer to this plan are that it would supply us with a multiplicity of candidates; every large local society would hold its caucus and present its candidate; the politicians would begin their work, not at the meeting, but as soon as the secretary issued his annual circular, and the successful candidate would not in all probability be a choice of the majority of the Institute.

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## GLEANINGS.

## GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,  
CLARENCE BARTLETT, M.D.,E. M. GRAMM, M.D.,  
W. W. VAN BAUN, M.D.,

**THE TUBERCULOUS NATURE OF THE SO-CALLED SIMPLE PLEURITIC EFFUSION.**—In order to learn the remote event in cases of pleuritic effusion, Dr. Alfred G. Barrs took the names and addresses of all the patients suffering from that affection who were in the Leeds Infirmary from the year 1880 to 1884 inclusive, and endeavored to learn if they were still living; if so, in what condition, or, if dead, the cause of death. There were 114 cases of pleuritic effusion that were proper cases for inquiry. Of these, 40 were cases of empyema, and 74 were cases of pleurisy with effusion. Of the 74 pleurisies with effusion, 32 are dead and 25 are living, and 17 could not be traced; that is, there had been a death-rate in the cases that could be traced of 57 per cent. In the 32 fatal cases, the average age of the patients was 32.5 years, the maximum being 54 and the minimum 3. As to the duration of life after the onset of the disease, there died in hospital 3; died the day after leaving the hospital, 1. In the remaining 28 cases the average duration of life was 2½ years, the maximum being 5 years and the minimum 6 months. The causes of death in the 32 cases were as follows: known phthisis, 14; probable phthisis, 1; hip disease, 1; tubercular meningitis, 1; acute tuberculosis, 1; pleurisy, 3; "dropsy," 2; "hydropericardium," 1; unascertained causes, 8. As a result of his investigations the author adopts the conclusions of Mayer respecting the after-event in pleuritic effusion as follows: 1. The majority of cases of simple idiopathic pleurisy, or of pleurisy from exposure to cold, conceal or reveal a tuberculous process. 2. A careful study of the lung in the neighborhood of the effusion is more important as regards the prognosis in any given case than the study of the effusion itself. 3. The immediate prognosis in cases of pleuritic effusion is, under present conditions of treatment, almost always favorable; the remoter prognosis, on the contrary, should always be more guarded.—*British Medical Journal*, May 10, 1890.

**DIAGNOSIS OF IODOFORM INTOXICATION.**—M. Burlureaux, speaking of the means of recognizing iodoform intoxication, relates the case of a soldier who was admitted to the military hospital for a scarlatiniform eruption, which commenced on the left arm three days after the application of an iodoform dressing for a wound of that member. This eruption was followed by desquamation, and, in spite of the absence of sore throat and albuminuria, scarlatina was diagnosed. However, learning that iodoform had been used, and that the patient complained of a disagreeable taste, a piece of silver was placed in the mouth, and immediately a garlic taste was experienced, which Poncet, of Lyon, described as characteristic of iodoform. In mixing some of the saliva with calomel, canary-yellow was obtained, which was due to the formation of mercurial iodide. M. Burlureaux thinks that both of these signs may be utilized in determining intoxication by iodoform or iodide of potassium.—*Medical Press and Circular*, April 23, 1890.

**ATTACKS OF MANIACAL DELIRIUM DURING INFLUENZA.**—A patient of Dr. Joffroy was taken with high fever, excessive headache, sore throat, and a light scarlatina-like eruption. The latter disappeared in a few days with bran-like desquamation. As there was neither the roseola spots of typhoid fever, nor the sensitiveness in the iliac region, the physicians thought of meningitis on account of the steady maniacal delirium, with total loss of memory and inability to recognize his parents and friends. Sometimes he acted as if absorbed in thought, then he sang, and tried to get out of bed to go to his work; or again he was full of fears that he would be killed. For two weeks this delirium lasted day and night. The temperature kept up to 103° in spite of large doses of antipyrine and quinine. On the

eighteenth day fever and delirium disappeared gradually. A few days afterwards he was convalescent, and soon able to attend to his business as well as ever.—*Bullet. Med.*, 26, 1890.

**ATROPINUM THE ANTIDOTE TO MORPHIUM.**—Bing shows that the lowered blood-pressure caused by morphine may be eased up by a good dose of atropine; the cardiac vagi, morbidly irritated by morphine, are rapidly calmed down, and the slow and imperfectly-acting heart urged on to more satisfactory action, removing thus simultaneously the two most dangerous symptoms of morphine poisoning, the reduction of blood-pressure and the retardation of the pulse. In one case of morphine poisoning there was already cyanosis; depressed breathing; irregular, weak and rare pulse; enormously contracted pupils; heavy coma; temperature 36° in rectum. Three-quarters of a gramme of atropine, given in durated doses by hypodermic injections, saved life.—*Fortachr. d. Med.*, 5, 1890.

**NEUROSIS OF THE STOMACH, AND THE CONDITION OF THE GASTRIC JUICE IN DIABETES MELLITUS.**—Prof. Rosenstein, of Leyden, closes his essay with this résumé: 1. In many cases of diabetes mellitus free muriatic acid is absent in the gastric juice for a longer or shorter time, which absence points strongly to a state of gastric neurosis. 2. In many cases of diabetes mellitus we meet an extensive atrophy of the mucous membrane of the stomach in consequence of an interstitial gastritis. 3. Where for a long time free muriatic acid is absent in the gastric juices, it proves the atrophy of the glandular apparatus caused by interstitial inflammation. 4. The diabetic secretory neurosis of the stomach, the absence of the patellar reflex and other neuroses, do not stand in a direct relation to the gravity of the case, in so far as it depends on the percentage of sugar, acetone and diacetic acid.—*Berlin. Klin. Wochenschr.*, 13, 1890.

**HYSTERICAL MUTISM.**—Charcot writes that hysterical mutism sets in suddenly, often after mental excitement, as after a fright, or at the end of an hysterical fit or during the course of an hysterical aphonia, or even after a simple laryngitis. It may last from a few hours to several years, with free intervals. There is at the same time absolute aphonia, differing thus from deaf and dumb persons, who can ejaculate the loudest screams. There is a motory aphasic state, though they can move lips and tongue. Intelligence remains perfectly normal, and answer promptly in writing or by gestures. When asked for the reason of their mutism, they all point to the throat as the seat of their trouble. In some cases anaesthesia of the pharynx and uni- or bilateral hemianæsthesia were observed. It is of psychical nature, as it can be produced and cured by hypnotic suggestion.—*Munch. Med. Wochenschr.*, 12, 1890.

**RELATION OF THE PHYSIOLOGICAL ACTION OF DRUGS TO THEIR THERAPEUTIC ACTION.**—Iodide of sodium is not a neutral body, which shows only the action of iodide, for it is the sodium which diminishes the arterial tension. Physiologists are in error, as Claude Bernard has already shown, when they make conclusions on the action of drugs on the human body from experiments on animals. The effects may even differ in the same animal. Experience has demonstrated that sulphate of quinine acts differently in two febrile patients, as it has no action on the bacillus of erysipelas, but responds to the bacillus of typhoid fever. Some affirm that digitalis acts only on the pneumogastric nerves, and not on the cardiac muscle. Buchard is sure that it acts quite differently on a healthy person from what it does on a sick person. Its effects may vary even according to the phases of the disease. Alas! that doctors constantly change their fixed ideas; that physiology rests so largely on hypothesis, and we must, therefore, especially rely on clinical experience.—*Bull. Med.*, 26, 1890.

(Straws show which way the wind blows. The best minds in the old school are dissatisfied with their antiquated notions and fashionable experiments. Let us give them rope enough, and after groping long enough in the dark, the light of *Similia Similibus Curantur* will finally dawn upon them. Only let our school be firm in the application of nature's great law.—S. L.)

**DIFFERENTIAL DIAGNOSIS BETWEEN TABES DORSALIS AND FRIEDREICH'S DISEASE.**—In tabes dorsalis (locomotor ataxia) the lesions of the posterior roots always correspond in degree and extent to the sclerosis of the corresponding columns, while, in Friedrich's disease, the changes in the posterior roots fail to correspond with

those of the posterior columns, disease of which latter being always far more pronounced. The absence of sensory troubles in Friedreich's disease may here find its explanation, as the peripheral nerves are here not so much affected, while in locomotor ataxy we often meet a peripheral neuritis.—*Semaine Med.*, 9, 1890.

**ANTIPYRINE.**—Antipyrine, in combination with other drugs, decomposes easily. A mixture, containing four grammes antipyrine and five grammes chloral to fifteen grammes water, forms a milky emulsion and an oily liquid is eliminated. Antipyrine, in combination with extract cort. cinchone, produces a precipitate which contains all the active parts, and the liquid contains hardly a trace of the drug. Antipyrine, mixed with salicylate of soda, forms a sticky mass. It ought, therefore, to be given alone with some simple corrective.—*Bull. Med.*, 16, 1890.

**TREATMENT OF CHRONIC BRONCHIAL CATARRH IN CONSEQUENCE OF EMPHYSEMA.**—Causes of the catarrh are (1) atmospheric influences; (2) inhalation of mechanically or chemically irritating substances; (3) chemical vapors; (4) rarefied air and heat, which favor congestion and the swelling of the bronchial mucous membrane. The causes must be removed, and the patient put under the most favorable hygienic conditions. He must pass most of his time in the fresh air, use sea-bathing, five to ten minutes at a time, thirty to forty baths; during spring and fall, hydrotherapeutics at home, at first simple sponging, later the douche for a half or a whole minute. After the bath, massage, gymnasium and marching. In asthmatic attacks, compressed air ought to be inhaled and rarefied air exhaled. The sovereign remedy is kali iod., two, four, five or ten grammes *pro die*. When the mucous secretion is too copious, tar-water, twelve to fifteen drops in water, morning and evening, should be administered; or, where the stomach rebels against it, turpentine may be inhaled. Where the secretions are putrid, turpentine or carbolic acid, in larger doses, may be used; the nephritis, which may set in, soon passes away. Alkaline mineral waters are certainly useful.—*Deut. Med. Zeit.*, 1890, p. 90.

**BORAX IN THE TREATMENT OF EPILEPSY.**—Dr. Stewart, reporting a series of cases of epilepsy treated by borax, notes that the drug exerts a peculiar influence over nocturnal seizures, and that it is in cases where the fits are solely of that kind that the greatest benefit can follow its use.—*The Lancet*, April 26, 1890.

**TREATMENT OF PHTHISIS BY THE INTRA-PULMONARY INJECTION OF NAPHTHOL CAMPHOR.**—In continuation of an earlier experience in which local application of naphthol camphor was used beneficially in the treatment of wounds, Fernet (Société de Therap., Paris, July 10, 1889) has injected it into the lung tissue in certain forms of phthisis.

In most cases of lung tuberculosis a latent period occurs before the lesion becomes pronounced and general nutrition is influenced. It is in this initial period intrapulmonary injection is indicated. In previous cases by Robinson, True, Lepine, Schmidt, etc., it has been attempted to destroy the infection process through antiseptic injections by lessening the flow of pus or decreasing its production. Fernet seeks to favor cicatrization of the infiltrated tissues, and thus to hasten the healing process.

In four patients in the so-called second stage of tuberculosis with softened spots on both lungs, forty-one intra-parenchymatous injections were made, one or two each week. By means of a Pravaz syringe, .15 of naphthol camphor were injected, containing about two centigrammes of boraphthol. The injection was made just between the axillary line and the sternum in the first intercostal space, with antiseptic precautions, care being taken to avoid pricking any large vessel. In twenty-two out of the forty-one injections no unpleasant results were noticed; in the others slight complaints of pain in respiration, pain in the arm or along the cubital nerve. Occasionally a paroxysm of cough followed, or hæmoptysis, slight in amount and of short duration. A passing pneumothorax was in one case seen. Of the four patients, three left the hospital distinctly better. The fourth (in which there was a cavity) was not improved.—*The Medical Chronicle*, May, 1890.

**OSTEO-SARCOMA OF THE LUNGS.**—Kozlowski, in *Le Progrès Médical*, reports the following case: G. F., a soldier, aged 24, was admitted into the Kieff military hospital on February 3d, for a painful swelling of the knee. There was pain also in the thigh and leg, and the limb was carried in a state of semiflexion. Tinct. iodi. and a compression bandage were ordered. The swelling grew larger, and as the

evening temperature was invariably high, it was thought to be a case of suppurating knee-joint. It was punctured, and some sero-sanguinolent fluid, without a trace of pus, was drawn off. The joint was then injected with a 9 per cent. solution of carbolic acid, but the pain and swelling augmented, and the patient grew steadily worse. On April 23d, amputation in the middle third of the thigh was performed. The joint, when examined, was found to be filled with rose-colored granular masses, which had eaten into and separated the articular cartilages from the epiphyses. The crucial and part of the lateral ligaments were destroyed, and the bony parts around were soft and cut easily with the knife.

There was no pus present. Patient convalesced well, and left hospital with the wound completely healed.

In September he was readmitted for pain in the chest, cough, and occasional expectoration of blood. His appearance was that of a man in the last stage of phthisis; cachexia was extreme. There was dulness in patches over both lungs, especially at the apices and bases, and in one or two areas a highly tympanitic note could be obtained. The breathing was pronouncedly vesicular in type, with a bronchial character in the intrascapular regions. Purulent expectoration, sometimes stained with blood. The diagnosis was phthisis, following "white swelling" of the knee. A month later the patient died. Autopsy: The left lung was strongly adherent to the costal pleura and the diaphragm. It was greatly enlarged, weighing 1600 grammes. Over the surface were scattered numerous eminences, white in color and firm to the touch. The lung, when cut into, was seen to be infiltrated with masses varying in size from that of a hemp-seed to that of the fist. They had distinct limits, and did not pass into the ordinary lung tissue. They presented all the characters of osteoid new formations. Here and there were cavities filled with detritus and coagula. In the inferior lobe was a very large one, in which were found numbers of pieces of the osteoid material. The rest of the lung was in a state of hepatization, and the smaller bronchi contained pus. The bronchial glands were greatly enlarged. The right lung weighed 1080 grammes. Like the left it was infiltrated with numerous tumors of all sizes and of the same character. The other organs were healthy, and the operation wound was perfectly cicatrized. The minute structure of the new growth was that of an ordinary osteosarcoma.—*The Medical Chronicle*, May, 1890.

**CHOREA TERMINATING FATALLY FROM ACUTE PARALYTIC DISTENSION OF THE STOMACH.**—Dr. Herbert H. Brown reports a case of chorea which had been treated by large doses of chloral. bromide of potassium, Fowler's solution, hyoscyamus, cannabis indica and salicylic acid, given at different times in the course of eleven days. At the end of that time the choreic movements had entirely ceased, but a most persistent vomiting appeared. Distension of the abdomen became a marked symptom. On the thirteenth day the doctor was hurriedly summoned and found the patient in collapse, with small thready pulse. The abdomen was greatly distended and resonant on percussion. Death took place twelve hours later. An autopsy revealed the fact that the stomach was enormously distended and occupied nearly the entire abdominal cavity; the intestines were quite empty and collapsed and compressed into the pelvic cavity.—*The Lancet*, April 19, 1890.

**A NEW REMEDY FOR SEASICKNESS.**—Dr. Charles W. Hamilton, a surgeon in the royal navy, has found the kola nut an efficient remedy in the treatment of seasickness. Half to one drachm of the seed chewed slowly was followed in about forty minutes by complete cessation of the various symptoms of mal-de-mer.—*British Medical Journal*, May 10, 1890.

**ACTION OF SMALL DOSES OF NATRUM SULPH.**—Patients are often sent to Marienbad for the regulation of their abdominal functions with the advice of their physicians. While there they drink a great deal of the mineral water, and it was often the case that the more they drank and saturated the organism with it, the worse they felt. Naturally the thought arose with Heck that small doses might be more effectual in overcoming this irregularity in defecation. This he found to be so. The biological law, so well defined by Harnack, Arndt and Schulz, demonstrates that what is a weak dose for a healthy organ becomes a strong one in a diseased one. Small doses of Glauber salts show in many patients a far greater resolving action than large ones, though the why and wherefore may not be so easy to explain.—*Wien. Med. Presse*, 13, 1890.

**TREATMENT OF INSOMNIA** (*Journal de Medicine de Paris*).—Dr. Altorf recommends a plan of producing the sedative effects of a warm bath, which can easily be carried out. He recommends that the loins and abdomen be wrapped in linen cloths which have been dipped in lukewarm water. These cloths are covered with a water-proof sheet so as to prevent evaporation. The whole is retained by a flannel bandage so that all loss of heat is obviated. The author claims to have obtained surprisingly good results from this simple method of treatment.

**INFLUENCE OF GYMNASTIC EXERCISES ON THE DEVELOPMENT OF THE BODY.**—After five months' observation of one hundred gymnasts, the following results were obtained: The circumference of the chest increased  $2\frac{1}{2}$  centimetres in 76; the muscles of the upper arm, 1.28 in 82; of the forearm, 0.57 in 62; of the thigh, 1.38 in 63; of the calves, 0.82 in 36. The strength of the subjects had also increased in proportion to their muscular development. Eighty-six could lift about 28 kilogrammes more; the grasps of the hands had increased 10 kilogrammes in 81. Muscular action was better performed, owing to the less amount of fat. Accidents were not of frequent occurrence. During six years, among eight thousand gymnasts there were only eight luxations, two fractures and nineteen minor accidents; that is nearly one accident yearly to one thousand gymnasts.—*Algern. Med. Centr. Zeitung*, 26, 1890.

**CYANOSIS IN MIDDLE LIFE FROM PATENT FORAMEN OVALE.**—A careful examination of the inter-auricular septum in adults shows, according to Cruveilhier, Parot, Bizot and others, that there is in some 15 per cent. of cases, or even more, a very small opening between the auricles in the course of the original oblique passage of the foramen ovale, which has been prevented from showing any symptoms of leaking during life, owing to its complete occlusion by the carefully fitting valve of Vieussens. So long, at any rate, as the pressure of the blood is greater in the left auricle than in the right, the valve is kept in a position in which the passage of any blood from one auricle to the other is quite impossible, even granted that there is an opening through the foramen ovale. It is possible, however, that if the pressure in the right auricle is markedly in excess of that in the left, a slight opening of the communication may be effected. M. M. Bard and Curtillet, of Lyons, bring forward two cases which admirably illustrate these facts. The first case was that of a porter, aged 47, who had had acute rheumatism when a young man in the army, but completed his service without difficulty in five more years. No syphilis or excess of alcohol could be made out. For twelve years subsequently he served as a porter, with no discomfort beyond slight rheumatic pains, until he came into the Hotel Dieu in November, 1887, with advanced phthisis and some palpitation, and cardiac trouble without oedema. On examination of the heart there was found to be extreme irregularity of rhythm, an ill-defined, widely spread apex beat, retraction of the walls of the thorax in systole, and a faint irregular systolic murmur, culminating about the apex. After a month or two under treatment with digitalis, the murmur became inaudible, the action of the heart was stronger and more regular. There were permanent dyspnoea and oedema for a time. But before long all the serious symptoms were those of tuberculosis, which led to his death four months after his admission in February, 1888. Besides general tuberculosis affecting the brain, the immediate cause of death, the *post-mortem* examination showed an adherent pericardium and enlarged heart. All the valves were normal except the mitral, which were contracted, and the mitral orifice was somewhat stenosed and covered with a few vegetations. The unexpected point was that the foramen ovale was open and large enough to admit the forefinger easily when it was passed down to it obliquely. A careful consideration of the close adaptation of the valve led the observer to the conclusion that the perforate inter-auricular septum could not have led to any leakage in life so long as the pressure in the left auricle was greater than in the right; and certainly there had been no cyanosis observable.

In the second case, that of a coppersmith, aged 54, the patient had had very good health until he was 42, and then had some bronchitis which laid him up for five months, and which had recurred during several winters. However, in November, 1887, he was well enough to go to Beyrout on business. There he was seriously ill for a month, with sudden headache and delirium, without cough; he improved after bleeding and quinine. On his way back he caught cold, and arrived at Lyons in a state of acute bronchitis with very marked cyanosis.

The action of the heart was regular, and there were clear sounds at the apex, but





After this friction, bathe again. After coming out of the bath, dust the entire body with powdered starch. The method which he thus advises, Prof. Fournier says, will avoid many of the consecutive eczemas. Before putting on his clothes, the patient should be sure that they are clean. They may be effectually ridded of the parasite by continued exposure to a dry heat of 100° C.

In cases of adults having a high grade of skin inflammation with eczema, lymphangitis, and furuncles, this method is very painful, increasing the already existing inflammatory conditions. This treatment is also not applicable for children, especially those at the breast; it would tend to excite eczematous dermatitis, irritate their nervous systems, and determine convulsions. In both of these classes of cases the best plan of treatment will be to combat the inflammation of the skin. In children, after the subsidence of the inflammation, frictions of soap should be used, followed by baths. After three or four days the following ointment should be used twice daily:

R. Styrax,	:	:	:	:	:	:	:	:	:	2 parts.
Olive oil,	:	:	:	:	:	:	:	:	:	1 part.

This treatment is well-tolerated and a cure is rapidly effected.—*Journal des Maladies Cutanées et Syphilitique*, 6, 1890.

## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

**STATISTICS OF FORCEP DELIVERIES AT THE ROYAL MATERNITY IN DRESEN.**  
—From September 1, 1883, to January 1, 1889, there were 7322 births, 206 of which (2.8 per cent.) were completed by the forceps; 187 of these were typical applications at the floor of the pelvis, 19 of these were atypical applications at the brim of the pelvis. In 19 of these the forceps were applied unsuccessfully. In the 206 patients delivered by the forceps, 148 were primipara and 58 multipara (71.9: 28.1 per cent.), 95 patients (46 per cent.) had narrow pelvis. There were 89 girl babies and 117 boys (100:132). 35 of these infants died (17 per cent.). The actual mortality of the children for the forceps operation was only 12 per cent., as in 10 cases there was no certainty that the children were living when the forceps were applied and some of them died later from other injuries. Facial paralysis was observed in 22 cases, half of these had recovered when they left the hospital. 7 of the mothers died, though not in consequence of the application of the forceps. 119 (57.7 per cent.) suffered severe injuries to the soft parts. 141 (68 per cent.) of the lying-in women remained free from fever. 20 (9.7 per cent.) had slight fever, but were dismissed on the twelfth day. 45 (21.8 per cent.) had more fever and 7 had parametritis. Münchmeyer emphasizes that the application of the forceps is the most bloody of all obstetric operations, and the use of the instrument must be limited as much as possible and never be applied for the convenience of the operator.—*Archiv. für Gynäkol.*, xxxvi., 1, 1890.

**HERNIA OF THE GRAVID UTERUS.**—The patient had been delivered of her first child by craniotomy. In her second delivery version was performed and the physician tore the body away from the head in his efforts at extraction. He then performed Cæsarian section to get out the head, though the true conjugate diameter measured 6½ cm. Four years and a half later the patient became pregnant again, and near the end of her pregnancy came to the Dresden clinic. The rectal muscles had separated, allowing the pregnant uterus to prolapse between them, covered only by the peritonæum and skin. In the erect position the uterus hung so low down as to completely cover the genitals. Ovaries, ligaments, bloodvessels, aorta, interior of pelvis, etc., could be felt distinctly through the abdomen. The membranes had ruptured, but the cervix contained numerous cicatrices, which prevented dilatation. A colpeurynter was placed in the cervical canal to dilate it, and by this means the patient was delivered in a perfectly natural labor, excepting post-

partum hæmorrhage, which required the manual extraction of the placenta and an intrauterine douche of two quarts of hot (115°) 5 per cent. carbolic solution to control it. The child was poorly developed and only lived twenty hours after delivery.—Sperling, *Archiv. für Gynäkologie*, 11, 1890.

**CÆSARIAN SECTION AT THE DRESDEN MATERNITY FOR FIVE YEARS.**—Twenty-eight conservative Cæsarion sections have been performed; three of the mothers died (10.7 per cent.). In the last twenty-five operations the mortality is 8 per cent. Twenty-seven of the children (96.4 per cent.) lived to leave the hospital, and one died. In comparison with these cases in which the uterus was preserved, there were seven cases of Cæsarion section with removal of the uterus. All of these recovered. Two of the children died before delivery; two died some days after labor; one died some hours after labor; two lived. These rates of mortality are by no means an indication that the Porro operation is always preferable to the conservative method. The circumstances of the case must decide the operation best to be performed. The Porro operation requires three to four weeks longer for recovery than the conservative method, but it provides against the recurrence of pregnancy. The Porro operation is to be performed when the usual operation by suture cannot be considered, or when the uterus is in a septic condition; if there is atresia from any cause preventing the escape of the lochia; where there are large tumors of the uterus, such as fibroids; also osteomalacia and complete relaxation of the uterus. If Cæsarion section is performed on account of cancer of the uterus, that organ should be removed if possible to prevent subsequent infection of the patient in the puerperal period from decaying portions of cancerous masses. Catgut hardened in chronic acid is the favorite ligature at the Dresden Maternity.—Münchmeyer, *Archiv. für Gynäkologie*, 11, 1890.

**MANUAL EXTRACTION OF THE PLACENTA.**—Ahlfeld states that in his clinic manual extraction of the placenta is only necessary in four out of a thousand cases if the expectant method is properly observed.—*Centralblatt für Gynäkologie*, No. 15, 1890.

(It is well to remember in connection with the above that the extraction of the placenta with the hand is more dangerous to the life of the patient than the application of the forceps or version.—G. R. S.)

**HEREDITY IN THE DURATION OF LABOR.**—Dr. Anvard has collected data on the subject which go to show that, when all causes interfering with normal labor can be strictly excluded, there is a family similarity in the duration of labor in successive generations. In one case the duration of the labor was unlike that of the patient's mother. The patient resembled her father in physical development, and on further inquiry her labor was found to correspond closely with that of her aunt and grandmother on her father's side.—*Arch. de Toccol.*

**A NEW METHOD OF TREATING UTERINE FIBROIDS.**—Rydygier proposes to ligate the internal spermatic arteries, the uterine artery, and the round ligament instead of performing castration. A fibroid treated in this way diminished 75 per cent. in four months.—*Wiener Klin. Wochenschrift*, No. 10, 1889.

**INCISION OF THE CERVIX TO PROMOTE DELIVERY.**—In a recent paper read before the Obstetrical and Gynecological Society at Berlin, Dr. Dühessen advocated deep incision of the cervix, and sums up his article as follows:

1. Superficial incisions of the lower portion of the cervix are useless unless the upper part of the cervix, i.e., the supravaginal portion, is fully dilated.
2. Incisions are chiefly indicated in primipara; for multipara only in abnormal rigidity or cicatrices of the vaginal portion.
3. Numerous superficial incisions about the external os are indicated for atresia, and agglutination of the external orifice is indicated when blunt dissection is unsuccessful.
4. If the os has dilated somewhat, and does not continue to do so, in spite of good pains, in consequence of rigidity of the vaginal portion, then chloroform or some other narcotic is to be used. Superficial incisions are not to be made till after long waiting and rupture of the membrane.
5. Should the labor continue for some time after the incisions are made, infection of the cut surfaces can only be guarded against by the most thorough subjective and objective antiseptics.

6. If there are positive indications, on the part of the mother or child, for terminating labor, bloodless dilatation of the cervical canal is only suitable for atresia or conglutination of the os uteri. If, in these latter cases, the os does not rapidly and completely dilate, and in all other cases of partially dilated external os uteri, if the completion of labor is necessary, the life of the child can only be saved and the mother be spared from uncontrollable injuries by deep incision of the cervix, extending to its junction with the vagina.

7. Two or three such cuts, one on each side, one anterior and a fourth posterior, will suffice to dilate completely the os uteri.

8. These deep incisions in the cervix are safe with antiseptic precautions. Infection is then only possible in cases already infected, but even then injurious effects are improbable. Further laceration of a deep incision does not occur. The hæmorrhage is trifling and does not require a suture.

9. By these deep incisions the mortality for mother and child is diminished in old primiparae, premature artificial rupture of the membranes, placenta prævia, and eclampsia of primipara, permitting safe delivery in the beginning of labor, or even toward the close of pregnancy.

10. Deep incisions are further indicated for prolapse of the cord and moderate dilatation of the cervix in primipara, so as to perform version with immediate extraction; also in flat or generally contracted pelvis and movable head at the brim where the prophylactic version is to be performed, also preliminary to the high forceps operation.

11. Deep incisions are to be made with Siebold's scissors under the guidance of the finger, after the proposed site of incision is stretched apart by bullet forceps.

12. In primipara, when the cervix is high up, the incisions in it are to be supplemented by deep perineal incisions, allowing the dilatation of the lower third of the vagina.

13. These deep incisions remove every obstruction, and improve the prognosis for both mother and child.

14. The incisions, 4 cm. long and 2 x 3 cm. deep, in the perineum, are best made by the scalpel, when the edge of the vagina is made tense in the forceps operation.

15. The hæmorrhage from the incisions is first arrested by the pressure of the child's body; after labor by tampons or hæmostatic forceps applied temporarily or, finally, by suture.

16. In applying the suture, great care must be taken to allow for the misshaped surface of the wounds due to retraction of the muscular fibres.

The entire article is published in the *Archiv. für Gynäkologie*, Heft I., p. 27, 1890.

The discussion which followed is printed quite fully in the *Centralblatt Gynäkologie*, No. 16, p. 283, 1890. It is interesting to note that the procedure was severely criticized and condemned in so far as it concerns the wide application recommended by Dr. Dühsen. Professor Ohlhausen voiced the opinions of many in remarking that incisions of the cervix are probably too little practiced at the present time, but their use is limited to cases of peculiar rigidity of the cervix, when the incision may be very useful. It is uncalled for in conglutination of the cervix. In the extension of these indications he is of the opinion that Dr. Dühsen has gone altogether too far. To undertake such incisions before the cervix has dilated, and even when the head is movable above the brim, and to follow them with immediate delivery by the forceps, is to throw overboard the foundations of obstetrical operations. Indeed, to recommend anything of the kind is to be considered questionable, dangerous and shows very little experience.

**GROWTH OF AN INFANT BORN AT THE TWENTY-SEVENTH WEEK.**—Holowks reports an infant born at this period which was only 37 cm. long, and weighed only 1300 gm. The minimal weight of a viable child has been stated by J. Veit to be 1600 gm. The regulation of heat is exceedingly important for premature children. The warm cradle, or cradle, the incubator, Tarnier's or Anverd's converse, Winkel's permanent bath or Schultze's glass-wool wrappings serve the same purpose. The child gained very rapidly after the second week, averaging a daily increase of 41.9 from the third to the sixth week. It had a wet-nurse.—*Centralblatt für Gynäkologie*, No. 14, 1890.

**COMPLETE PROLAPSE OF THE UTERUS IN A NEW-BORN CHILD.**—The infant was born with double pes equino-varus and lumbar spina bifida. It was otherwise large and well. On the seventh day it had diarrhœa, with uninterrupted tenesmus

and straining. Prolapse of the rectal wall, then of the vagina, and finally complete procidentia of the uterus followed in thirty-six hours. The uterus could be easily replaced, but came down again at once. The child died six weeks later from hydrocephalus. The autopsy showed no anatomical reason for the displacement which was evidently due to the pressure from the abdomen.—*Centralblatt für Gynäkologie*, No. 17, 1890.

**TRANSMISSION OF TYPHOID BACILLI FROM MOTHER TO FŒTUS.**—Dr. Hilderbrandt, Königsberg, relates an instructive case bearing on this point in the *Forta. der Medicin*. The investigation was made on a recently dead seven-months' fœtus of a woman suffering from typhoid fever. Bacilli from the blood submitted to pure cultivation gave other bacilli corresponding in size and shape to those of typhoid fever. As no other known bacilli are like those of typhoid, it was claimed that those in question were real typhoid bacilli. No notable microscopic organic changes were observed, except slight enlargements of the mesenteric glands. A few bacilli were found in both placenta and spleen. Experiments on animals, however, were entirely negative. In speculating on the manner of transit of the bacilli from the mother to the fœtus, the author points out two possible conditions under which it may have taken place. There may have been a primary passage of the bacilli with consequent death of the fœtus, or the fœtus may have died in consequence of the acute infective disease (no uncommon occurrence), and transudation have taken place through a softened and possibly torn placenta.—*The Provincial Medical Jour.*

**THE EARLY DIAGNOSIS OF EXTRA-UTERINE PREGNANCY.**—Taylor, in remarking on the early diagnosis of extra-uterine pregnancy, states that he can hardly conceive of a tubal pregnancy which could not be felt as a tubal tumor by the fifth or sixth week, and that tubal pregnancy is to be diagnosed with less difficulty in its early stages than at a somewhat later period when, through rupture, the tumor has lost its distinctive characters. The three signs of greatest service in forming a diagnosis at any early period is the following: 1. Amenorrhœa, followed after six or seven weeks by irregular hæmorrhage. 2. Absence of any uterine enlargement. 3. Tubal tumor, usually felt directly behind the uterus.—*Medical Press and Circular*, May 7, 1890.

**A DIFFICULT CASE OF TURNING RENDERED EASY BY PLACING THE PATIENT IN THE GENU-PECTORAL POSITION.**—Ensor reports a case to which he was called by a midwife, and in which he found not only a hand, but also a foot and a head presenting, the last being impacted in the pelvis, having forced down before it the posterior segment of the partially dilated os and cervix uteri. The membranes had been ruptured a long time before, and pains were almost incessant. Efforts to turn with the patient in the ordinary position were unavailing. She was then placed in the knee-chest position, so as to allow the uterus and its contents to fall forward and downward by their weight. He was then able with the greatest of ease to effect version by slight traction on the foot and simultaneous pressure on the head.—*British Medical Journal*, April 19, 1890.

**PELVIC ABSCESS TREATED BY INCISION.**—Mayo Robson, after reporting a series of cases of pelvic abscess treated successfully by abdominal incision, remarks that all the cases would have died but for the operation, whereas the treatment pursued cured several and greatly benefited all. Be the abscess ever so foul, and although it has been in communication with the bowel or bladder for long periods, it is, with proper precautions, quite safe to evacuate it through the peritoneum. After the evacuation of such foul abscesses and the cleansing of the cavity by syringing with an antiseptic, there should never be a suspicion of odor in the subsequent dressings.

No general rules can be adopted for the surgical treatment of these cases; each must be treated on its merits. When we have once made the diagnosis of pus within the pelvis, our course should be to evacuate it; unless fluctuation can be felt *per vaginam*, the plan of opening the abdomen, searching for, evacuating, and draining the cavity will, if done *secundum artem*, probably be found to yield the best results.—*British Medical Journal*, April 26, 1890.

**SUDDEN REMOVAL OF NERVE PRESSURE AS A CAUSE OF PAIN.**—Dr. E. F. Wells reports two cases in which sudden removal of nerve pressure gave rise to severe pain. Both were cases of labor. In the first there appeared about two hours after a perfectly normal labor, the most excruciating pain in the right leg, which gradu-

ally ascended towards the trunk. The pain was described as being continuous, expanding and almost unbearable. This patient during two subsequent confinements suffered in precisely the same way. The pain was much ameliorated in the last one by tightly bandaging with a rubber bandage the limb, from the toes to the pelvis. The second case was that of a woman who in five confinements suffered, beginning about one hour after parturition, with pain in the calf of the right leg, which pain continued for ten or twelve hours, rapidly attaining its maximum and gradually subsiding. In the last labor a constricting bandage above the knee gave great relief.

Sudden removal of pressure gives rise to pain in other than puerperal cases, as for example after the removal of a tight bandage, following catheterism of a distended bladder, etc.—*Lancet*, April 12, 1890.

**LAPAROTOMY FOR RUPTURE OF THE UTERUS.**—Dr. Gustav Braun reports a case of rupture of the uterus for a neglected shoulder presentation; the rupture was eight inches long and was circular in direction, from right to left, in the anterior wall of the uterus. The rent was sewed together with silk sutures. A tampon of iodoform gauze was inserted in the uterus and vagina to arrest hæmorrhage, and a drainage tube was also placed in the vagina. The patient died on the fourth day from diffuse purulent peritonitis (would it not be the better practice in such cases to remove the uterus as in Porro's operation? G. R. S.). Dr. Braun recommends laparotomy for incomplete rupture of the uterus, as the peritoneum may be peeled up from the uterus and form a sac containing blood clots or the placenta, which will undergo degeneration and cause septicæmia.—*Wien. Klin. Wochenschr.*, 2, 50, 1889.

**SUGAR IN THE URINE DURING PREGNANCY, LABOR AND CONFINEMENT.**—Ney examined twenty-four pregnant and one hundred and forty-eight lying-in women, in the maternity of Basle, for glycosuria by Trommer's, Boettger's, and the fermentation test. Among the pregnant women, he found four with glycosuria: in all of these the breasts were well developed, and milk could be expressed from them. During labor no sugar was found in their urines. During the lying-in state, he found sugar in the urine in four-fifths of the cases, and especially in those in which there were excoriations of the nipples and mastitis. The disturbed lactation, he believes, leads to the stagnation of the milk, and hence to excretion of sugar. Even in those cases where the supply of milk is plentiful, sugar is physiologically excreted, probably because the glands manufacture more milk than the babe can appropriate. Where no milk is secreted, sugar is not detected either before or after confinement. In most cases the sugar appears between the second and fourth days after labor simultaneously with the secretion of milk, but soon disappears. It may last longer when the milk supply is too copious. In ten cases where quantitative analyses were made, he found 0.8 to 1 per cent. of sugar; only once 2 per cent. Good food and care give a more copious excretion, while poverty and care make it disappear. The sugar in the urine of wet-nurses is, therefore, physiological.—*Med. Neuigkeit.*, 11, 1890.

**A SUBSTITUTE FOR INDUCED ABORTION IN MODERATE PELVIC CONTRACTIONS.**—In three cases of women with rachitic pelvic scoliosis, all of whom had borne children which could only be delivered after perforation and use of the cranioclast, Prochourics ordered the following diet during subsequent pregnancies: Breakfast, one small cup of coffee, 25 gm. of Zwieback; dinner, meats, eggs and fish, a small amount of green vegetables cooked with much fat, salad, cheese; supper, the same, with 40 or 50 gm. of bread and butter *ad libitum*. Water, soup, potatoes, pastry, sugar or beer not allowed. As a beverage, 300 to 400 c.c. of red or Moselle wine daily.

As a result of this diet the children were all born at term and alive. They were healthy and perfectly developed, but with scarcely any fat, and with less firmness of bone than normal.

The author believes that this method will save many children otherwise condemned to premature birth and probable death.—*American Journal of Obstetrics*, May, 1890.

**SHEET-SLING IN FORCEPS DELIVERIES.**—The crutches devised to steady the flexed lower limbs during operations do their work well, but are too cumbersome to carry. A satisfactory substitute is a sheet rolled and passed behind the neck and

under the bent knees. The thighs are flexed as far as possible. The extreme flexion of the knee gives the hand such a solid grip on the sheet that no sidewise slipping can occur, and the knees can be adjusted at any distance apart. The patient balances herself. She cannot kick. The only assistant required is the one who gives the chloroform and "hands things." It is a great help in low forceps deliveries, in breech extractions, in easy versions, and in the restoration of the perineum. Even in the severer cases that are major operations and require ether, operating table, and assistants, it helps. For Sims's position it should go back of the shoulder on the upper side.—*Archives of Gynecology*, May, 1890.

**PUERPERAL ECLAMPSIA.**—A correspondent reports seven cases of puerperal eclampsia treated with prompt and unusual success with veratrum viride. In a primipara who previous to her attack had had uræmic symptoms, stupidity, intense headache, etc., accompanying œdema, after four or five convulsions he administered twelve drops of Norwood's tincture of verat. viride. The pulse, which had been 100, was reduced to 78. In half an hour after the first dose another dose of twelve drops was given; again the pulse dropped; this time to 56. In a few minutes she became conscious, although she had been comatose from the beginning of the spasm, and remained conscious during her delivery, which was accomplished with little difficulty.—*Times and Register*, April 26, 1890.

**GNORRHOEA AS A CAUSE OF SALPINGITIS.**—Dr. Schmitt communicates to the *Archiv. für Gynäkologie* an instructive case of gonorrhœa in a woman. The first symptoms were found in the urethra and uterus, the discharge containing gonococci; then followed pains, frequent paroxysms of fever and emaciation to such an extent that after several weeks the removal of the left tube which was considerably thickened, seemed indicated. The operation, which consisted in salpingectomy and left ovariectomy, was difficult because of the extensive adhesions, so that pus entered the abdominal cavity, and the serous covering of the gut was torn in one place. Death occurred on the second day, and was found at the post-mortem examination to have been caused by peritonitis from perforation of the bowel. Both tubes were thickened, enlarged and full of pus containing gonococci, and the microscopic appearances were similar to those found in gonorrhœa when recovery is taking place. Some of the morbid changes could be explained by increased pressure due to the retention of pus. The tissues of the tubes contained no gonococci, which fact was probably due to the progress which had been made towards cure. The author was induced by this case to undertake a series of clinical examinations of the disease, and in 116 cases of acute or sub-acute gonorrhœa in women he found 27 complicated with secondary disease of the pelvic organs, four being also syphilitic. In most of these cases the gonorrhœa had extended also to the mucous membrane of the whole of the genital organs during the first two months after infection. He believes that gonorrhœa perimetritis is caused by the admission, through the abdominal orifice, of the tube of pus, which acts chemically and not through the gonococci it contains.—*The Lancet*, April 26, 1890.

**ON THE DIAGNOSIS OF PREGNANCY IN THE EARLY MONTHS.**—Dr. L. Eliot, in the *Jour. of the Amer. Med. Assoc.*, June, 1889, maintains that during the early months of pregnancy the condition may be suspected by the condition of the pulse, which has a most unusual steadiness, being unaffected in pregnancy by locomotion or standing, or by sitting or lying. This condition has already been noticed by others, Jorisseune in 1878, and Schapiro in 1881.

**CARDIAC AFFECTIONS OF THE MENOPAUSE.**—A frequent cardiac trouble associated with the menopause, says Professor Kisch, is tachycardia occurring in paroxysms. In the beginning of the climateric, when menstruation is becoming irregular, although the heart had been hitherto normal, women complain of attacks of palpitation, with or without apparent cause, lasting some minutes and recurring after several days. The feeling of increased heart-beat is very troublesome and is accompanied by a sense of anxiety and of pressure in the chest, throbbing of the carotids, pulsation of the abdominal aorta, with rushing of blood to the head, occasional muscæ volitantes, noises in the ears, giddiness, and even fainting. Objectively, the cardiac action is found to be increased, with frequency of the pulse from 120 to 150, which is unusually strong, well-filled and regular. The heart-sounds are normal. With these cardiac troubles, is usually combined a condition of bodily and mental unrest, inability to follow regular employment, or restlessness; sleep

is broken by dreams, and generally there is great nervous irritation. The ages of the sufferers range usually from thirty-eight to forty-eight. There is no appearance of anæmia; on the contrary, the patient looks well-nourished, strong and full-blooded. This paroxysmal tachycardia may remain during the whole of the menopause. The systematic use of mild purgatives is indicated, with dietetic treatment in the shape of bland food, while much improvement may result from active bodily movement, cold bathing and moist applications to the abdomen. Another form of heart-trouble associated with the change of life, shows the symptoms of cardiac weakness. It occurs usually in delicate women, who have suffered from chlorosis in youth, and from anæmia later on; or, in cases where the climacteric sets in with profuse menorrhagia, or in women who have suffered much from menorrhagia formerly, or have borne many children.

These complain much of heart-beating, the frequency not being so high as in other forms, though the pulse is weak, small, easily compressible, and sometimes intermittent or irregular. The action of the heart shows weakness and want of energy. Dyspnoea and attacks of cardiac asthma occur, sometimes with angina. Congestive appearances may be present, such as sudden chilling of hands and feet, often with oedema of the ankles, and sometimes there is albumin in the urine. It is very important in these cases to ascertain the condition of the pelvic organs. A third group arises from the tendency of fat to find its way into the heart as part of a deposit throughout the body generally. Women do not, however, suffer so much from this form as men, for, although the deposit of fat may be greater, the female organism is accustomed to such variations in the amount of adipose tissue, that the heart can accommodate itself more readily.—*Berlin Klin. Wochenschr.*, 50, 1889.

**RELATION OF MATERNAL TO FŒTAL CIRCULATION.**—E. Wertheimer and E. Meyer have studied this by injection of aniline oil into the blood of the mother at full time. This substance has the power of transforming the hæmoglobin of the blood to methæmoglobin. The presence of the latter in blood may be detected by spectroscopic examination.

The above observers found that, while the blood of the mother might show the presence of a large quantity of methæmoglobin in the blood, and a consequent diminution in its respiratory capacity, the fœtal blood remained free from methæmoglobin. In other words the toxic substance did not pass into the fœtal circulation, a fact the more surprising as it is found in the form of a soluble salt in the maternal blood.

There is a selection of material in the placenta. Thus Kunts found that, after injection of sulphindigotate of soda into the maternal circulation, a blue coloration appeared in the amniotic fluid, but not in the blood of the fœtus, nor in any of its organs. According to Krukenburg, iodide of potassium behaves in a similar manner. It might be supposed that the toxic substance had passed to the fœtus, but not in sufficient quantity to give the characteristic spectroscopic appearances, but even so small a quantity as one in a hundred thousand parts can be readily detected, so that this objection is not tenable. It is, however, noteworthy that the change of the hæmoglobin to methæmoglobin takes place in the corpuscles of the blood.

It still remains desirable to ascertain whether hæmoglobin or methæmoglobin in solution in the blood plasma can pass through the placenta to the fœtus—*Glasgow Medical Journal*, May, 1890.

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**THE EXCLUSION OF LIGHT IS NOT BENEFICIAL IN THE AFTER TREATMENT OF CATARACT OPERATIONS.**—Dr J. J. Chisolm, in a paper read before the Medical and Chirurgical Faculty of Maryland, April 22d, gave his experience during the past four years in the treatment of cataract operations. In this paper Dr. Chisolm reiterated his belief that these cases are best treated without the confinement, darkness and heavy bandages formerly insisted upon by all ophthalmic surgeons. He only closes up the eye he has operated on by a strip of soft salicylated

silk isinglass plaster, and then leaves the other eye open, so that the patient can see to walk about, find himself and make his own toilet. The operated eye can be sufficiently well inspected through the diaphanous plaster. By the fifth day the corneal wound has healed, and the strip of plaster is removed. His experience, which covers hundreds of cases, shows that eyes treated in lighted rooms escape much of the irritability which is found when the bandage is removed in the dark-room treatment. For more than four years the doctor has carried out this treatment, and is now more than ever satisfied of its superiority.—*Medical Record*, May 17, 1890.

**NASAL REFLEX CHOREA.**—Since 1886 Dr. A. Jacobi has seen at least four cases of general chorea from chronic naso-pharyngeal catarrh, deviation of nasal septum, *ozena*, hypertrophy of tonsils, etc. This state he thus exemplifies: A child, three, seven or ten years of age, will show a number of symptoms, which to most people do not appear those of any morbid condition, but simply the result of bad habits, for which it is punished. The parents are told that with puberty or sooner the child will get well, but instead it often grows worse. The symptoms consist in local convulsive movements, as twitchings about the face, winking of the eyes, horizontal and vertical frowning, twitchings of the angles of the mouth, shrugging of the shoulders, jerking of the arms, sometimes throwing about of the arms, hawking, slight cough, some nasal catarrh. This lasts a number of years, being better perhaps during the warmer months. On examination the nose will be found the seat of catarrh; the mucous membrane thickened; considerable discharge present; glands of the neck swollen, particularly near the angle of the jaw; sometimes there was *ozena*, one or both nostrils more or less obstructed; sometimes deviation of the septum; in every case a good deal of pharyngeal catarrh; the tonsils hypertrophied and presenting a number of follicular cavities; in a number of cases a little *œdema*.—*Medical Record*, May 17, 1890.

**OPTIC NERVE ATROPHY IN SMOKERS.**—Before the Ophthalmological Society of London, Mr. Lawford read a paper on optic nerve atrophy in smokers, based on nine cases in which the symptoms of the early stage so closely resembled those of toxic amblyopia that the diagnosis made at first was that of tobacco blindness. All the patients were men and smokers, usually consuming a large quantity of tobacco. Treatment by abstinence from tobacco, etc., led to no improvement; indeed, in most of the cases, sight became progressively worse. The general features presented by these cases were gradual failure in vision, with central negative scotoma for form and color. The ophthalmic signs were slight pallor of the temporal half of the disks, without visible alteration in the retinal vessels. The chief distinction between these cases and those of ordinary tobacco amblyopia was found in the peripheral limitation of fields of vision which was almost always discovered if sought for; whereas, in tobacco cases, the boundaries of the fields were in most, if not in all, instances normal. None of the patients under the author's observation had symptoms of spinal disease, but one man, aged 51, became insane some months after his sight failed. Mr. Lawford was of the opinion that tobacco was certainly a factor in the causation of the optic nerve disease. Mr. Adams Frost said that he looked upon these cases as those of tobacco neuritis, in which secondary atrophy supervened. He had long held the opinion that if vision deteriorated beyond a certain point, in tobacco amblyopia, recovery did not take place. Dr. Hill Griffith did not regard them as cases of tobacco neuritis, for he held that disease of optic nerves from tobacco was always followed by recovery on discontinuing the drug.—*Lancet*, May 10, 1890.

**ARTIFICIAL MATURATION OF IMMATURE SENILE CATARACT BY TRITURATION.**—Before the Ophthalmological Society of the United Kingdom, Mr. McHardy said that fully five years' experience with this procedure had convinced him of the following: Complete ripening of immature cataracts may be safely and almost certainly secured in from eight days to eight weeks, with preliminary iridectomy, with trituration of the lens through the cornea and pupil; the ultimate results (surgical and visual) of extractive operations in such cases are quite equal to the results of similar operations for senile cataracts which have been allowed to fully mature spontaneously; the removal of such artificially matured cataracts is entirely free from those risks, drawbacks, and after impaired ultimate results which follow from the removal of immature senile cataracts.—*British Medical Journal*, May 10, 1890.



**NASAL INTUBATION.**—This consists in placing in the nostril a tube of suitable material, size, and shape through which the respiration is performed, and also as a means of treatment for nasal diseases from various causes. After an experience of many years with metal and other materials, Dr. D. H. Goodwillie says it has been proved to his satisfaction that pure soft rubber is the best material for the intra-nasal tubes. Respiration can be performed during treatment. The tube gives little or no inconvenience to the patient, and is not seen externally. They are readily introduced and removed. They can be obtained of W. F. Ford of New York, and are made in sets of six sizes. The following are some of the nasal diseases in which the intra-nasal tubes have successfully been used:

1. Hypertrophy of the soft intra-nasal tissues, when the tube is used for a sufficient length of time to produce a change in the vascular tissue.
2. Deviations of the cartilaginous septum.
3. Intra-nasal hæmorrhage.
4. Fracture of the nose.
5. After the removal of hypertrophic tissue, deviations of the septum, polypi, etc., by surgical means.—*N. Y. Medical Journal*, May 17, 1890.

**GELSEMIUM IN ACUTE AND CHRONIC INFLAMMATIONS OF OPTIC NERVE AND RETINA.**—Dr. W. A. Phillips strongly urges more frequent use of this remedy in retinal and nerve inflammation, and believes its full value is far from being properly appreciated. As illustrative of its physiological action, he gives two instances in which five-drop doses of the tincture were sufficient to produce the characteristic symptoms of giddiness, headache, and heaviness of the lids, followed by almost total loss of vision. In one case, the accommodation failed first, while in the other the sensibility to retinal impressions seemed to precede the loss of adjustment. In about forty minutes after the five drops were taken the vision was reduced to  $\frac{1}{25}$ , could not be improved by lenses, and would continue from five to fifteen minutes. Normal vision returned in from one-half to two hours. There was not sufficient change in the ophthalmoscopic appearance to indicate impaired vision. Whether the continued use of this drug, even in persons so susceptible to its toxic effects, would eventually produce permanent impairment or total loss of sight in a manner similar to that produced by tobacco, can, of course, only be conjectured. Three cases of neuro-retinal disease, with impaired vision, are given in which the use of gelsemium appeared to act beneficially.—*Journal of Ophthal., Otol., and Laryngol.*, April, 1890.

**TREATMENT OF TRACHOMA BY EXPRESSION OF THE GRANULATIONS.**—Dr. Barton Pitte, in an interesting paper on granular lids, in speaking of the treatment, says he has given extensive trial to the process of squeezing out the granulation. He believes it especially adapted to the relief of the early presence of trachomatous bodies. In his hands it has been harmless and comparatively painless in its application, and has produced cures, often in a few weeks' time, without the usual destructive atrophy of the conjunctiva. His preference in the procedure is to use a diminutive pair of ring forceps, and, after cocainizing the parts, to strip the entire surface of the conjunctiva free from all visible granulations. This should be repeated from time to time, using as auxiliary means thorough and frequent working of the conjunctiva with  $\frac{1}{1000}$  or  $\frac{1}{2000}$  solution of bichloride of mercury, and occasionally, for the stimulating effect, especially in the more advanced chronic cases, an ointment of yellow oxide of mercury, and, when there is much thickening of the parts, with pannus and sluggishness of the absorption, the occasional application of the crystal of copper.—*American Journal Ophthalmology*, April, 1890.

**MOBILIZATION OF THE STIRRUP IN MIDDLE-EAR DEAFNESS.**—Since the introduction of this operation by Boucheron in a paper before the Académie of Sciences, at Paris, two years ago, a number of reports have been made, mainly on the European continent, more or less favorable to the practice. At the International Congress of Otology, September, 1889, Boucheron spoke of it as the operation of the future in otology. The special indications and contra-indications for the performance of this operation are still *sub judice*.

In a paper on the subject covering an experience of sixteen months, Miot describes the operation as follows: Under strict antiseptic precautions the membrana tympani is divided freely along its posterior bony attachment. The flap of the membrane so

formed is then turned forward, and a spatula-shaped sound introduced under the anvil-stirrup joint so as to bring it parallel to the legs of the stirrup. Resting the shank of the sound against the speculum, gentle leverage-pressure and traction are made on the ossicles until the stirrup is loosened. This failing to separate the stirrup from its position, a hook may be slipped between the legs of the stirrup and direct traction applied to the bone. As the stirrup leaves the oval window, traction should immediately cease. The separation of the ossicle is usually made apparent to the patient by a rustling or purring sound. Following the operation, the parts are irrigated with a 1000 sublimate solution, and the canal packed with iodoform or borie cotton. The dressings are changed every twenty-four hours, or oftener. Although Miot and Boucheron consider the operation practically without risk to the patient, other speakers condemned it as a dangerous procedure on account of the difficulty in securing complete antiseptis.—*Archiv. für Ohrenheilkunde*, 29 Band, 4 Heft, 1890.

**SLITTING OR TEARING OPEN THE TONSILS.**—Conglomerations of secreta are often seated in the lacunæ of the tonsils, and these keep up a constant irritation of the tissue of the glands, and render them more liable to inflammatory processes and infections. They frequently cause chronic pharyngitis, paræsthesiæ and hyperæsthesiæ in the throat. The removal of these conglomerations can be easily accomplished. A hooklet is pushed into the lacunæ of the tonsils, and its dull end pressed downward or upward, according to the location of the offending mass, and then tears open the bridge formed by the median wall of the lacunæ, which are thus changed into open sulci, and they are cleaned up by deglutition. It is always advisable to preface this little operation by pencilling the parts with cocaine, as thus the whole procedure will be without pain.—*Berlin. Klin. Wochenschr.*, 3, 1890.

**ARTERIAL PULSE ON THE VELUM PALATI.**—Muella discovered rhythmical pulsations of the velum palati in a case of aortic insufficiency with intercurrent angina. With every pulse in the carotids the tonsils and the palatal arches rose, as if approaching the median line, while the free edge of the palate and the aorta dropped, as it were, by a rhythmical motion, causing a narrowing of the faucial cavity and simultaneously a momentary increased redness of the mucous membrane. These pulsations continued after the angina was cured. Dr. Merklen describes a similar case in a young man, suffering from disease of the heart in consequence of articular rheumatism, who had mitral and aortic insufficiency with hypertrophy of the left heart. With the classical symptoms of aortic insufficiency and capillary pulse on the nails there was decided pulsation of the uvula and of the velum palati.—*Gaz. Hebdom.*, 11, 1890.

## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

**ELECTROLYSIS IN THE TREATMENT OF STRICTURE OF THE RECTUM.**—Dr. Robert Newman, in concluding a lengthy communication on this subject, advances the following propositions based on his experience: 1. Electrolysis in the treatment of stricture of the rectum is not a panacea; on the contrary, failures may happen; and probably will ultimately fail if the stricture is due to carcinoma. 2. Electrolysis will give improvement to the rectal stricture when all other means have failed. 3. Electrolysis will cure a certain percentage of cases without relapse better than other modes of treatment, and without the necessity of an after-treatment or using bougies. 4. The best chances for a cure are with the fibrous inflammatory strictures. 5. The best mode of treatment is by a metallic bulb as negative, weak currents, and intervals of four days to two weeks.—*Journal of the American Medical Association*, May 17, 1890.

**ASEPSIS OF INSTRUMENTS EMPLOYED IN THE URETHRA.**—Dr. Picard writes in the *Gazette des Hôpitaux* upon the subject of asepsis of catheters and sounds before they are passed into the urethra and bladder. Respecting the means to be employed to secure asepsis, the author confines himself to those easily secured by the general

practitioner. Metallic instruments are most easily disinfected. Boiling in simple water or in salt water is regarded as giving the necessary guarantees. Boiling in carbolic water is preferable, but often impracticable. Soft or semi-soft instruments are more commonly employed, and require greater care. The soft, red, caoutchouc sound, called after Nélaton, which is most extensively employed, is one easily disinfected and kept rigorously clean. It may be dipped for a few seconds into boiling-water, or it may be kept constantly in a strong antiseptic solution. It is recommended to wash the sound, thus kept in strong antiseptics, before using, either in boiling-water or boric acid solution. After boiling, the instrument may be taken up with a clean forceps and placed in a jar containing a saturated solution of boric acid. A thread previously fastened in the end of the sound is slipped into a slit in the cork, and the sound is thus suspended and can be readily withdrawn without handling when needed. Semi-soft gummy catheters and sounds are not so easily sterilized. They should be placed in tubes whose open extremity is filled with absorbent cotton. The tube is then placed in boiling-water, and allowed to remain for half an hour, keeping the interior of the tube at 100° C. During this time this heat will sufficiently sterilize the tubes. It will be more prudent to repeat this process several times at intervals of twenty-four hours, for while this temperature destroys adult bacteria, it is without effect upon the spores. The sounds can be sterilized by placing in a tube of boiling-water.

The hands of the physician should be thoroughly cleansed and rendered aseptic. The meatus and glans penis of the patient should be washed in a sublimate solution or with hot water. If the urethra is already infected, it should be washed out with a saturated solution of boric acid.—*Journ. of Cut. and Gen. Ur. Dis.*, May, 1890.

**DISLOCATION OF THE PENIS BENEATH THE SKIN OF THE SCROTUM.**—Malinowski records a case of very unusual injury to the penis. A man who had been employed in minding a horse that was working a mill, got entangled in the machinery, the trousers being drawn between a horizontal and vertical cogged wheel, and the penis was injured. There were two great wounds; one, an extensive rupture of the integument of the scroto-penile fold on the left side, the body of the penis itself slipping under the skin of the scrotum. He was attended in a rural district by a hospital sergeant, who did not reduce the dislocation, or suture the wounds, but contented himself with applying antiseptic dressings. In about three weeks the man had quite recovered. From the first there was no swelling of the scrotum and no difficulty in micturition; the only thing he complained of, was the impossibility of coition. When he was admitted under Professor Levshin, four months after the accident, the glans was seen to be protruding from the wound in the left scroto-penile fold, the lips of which had closed around the sulcus, the rest of the penis being felt as a perfectly movable body beneath the skin of the scrotum and the skin of the penis, hanging down in front of the scrotum like an apron attached to the cicatrix by its inferior border. This skin or so-called cutaneous tube (Nélaton) of the penis, the lumen of which was obliterated, was first made permeable and dilated by means of tents, and repeated attempts made to return the body of the penis into it. Ultimately, however, these were abandoned, and recourse had to a plastic operation, the body of the penis being released by slitting up the scrotum, and a new covering formed for it partly outside of the scrotal integument and partly out of the proper skin. The result was entirely satisfactory as to the power of coition. There was, however, some shortening of the organ.—*The Lancet*, April 12, 1890.

**INDICATIONS FOR ABDOMINAL SECTION, AND THE DETAILS OF ITS PERFORMANCE.**—In an address before the Cardiff Medical Society, Tait runs over this important subject. Exploratory incision is earnestly advocated as an aid to diagnosis, early and late. Even the two or three per cent. mortality cannot be attributed to the operation, but rather to the, at times, existing desperate morbid condition. Aside from this, the indications are familiar to every operator. As to details, simplicity is the great desideratum. Forceps, which also take the place of retractors, a sharp knife and a known number of sponges. The latter are washed thoroughly and kept dry, as they cannot decompose in this state. Instruments are clean and kept in water to wash off blood, etc.; coagula are thus kept out of the wound, as they would be a nidus for germs; this is more to be feared than the germs themselves. The water for the sponges and instruments is "tap-water," but the basins are scrupulously clean. The same water is used for irrigation or douching the abdomen. The patient should be under the surgeon's care at least forty-eight hours before operation. Hospital-trained nurses are a nuisance, and cannot compare with

those trained by the surgeon himself. The bed is a narrow one, with a spring mattress; a laxative the evening before the operation is followed by an enema the next morning. The operating table is narrow. Two parts of ether and one of chloroform are used in patients under forty-five, the proportion of the latter being increased after that age. The anesthetist is to attend to his patient and do nothing else. Another assistant keeps his mouth shut and does only what he is told! A nurse attends to the sponges. The incision is made down to the tendon; the rectus sheath is opened and split; the peritoneum is picked up and nicked between two forceps, and the opening enlarged over the finger. The point of election is the linea alba, the "centric incision." Once it becomes eccentric, its location must depend upon the indications, the tumor being attacked at its most prominent point. Drainage is to be used when there is fear of hæmorrhage. This has reduced the mortality ten to fifteen per cent; the older the patient the more need for drainage. To Koeberer is given the credit of abdominal drainage and the hæmostatic forceps, "the scissor artery-forceps." For closure of the wound, silk is to be used (as well as for ligatures), with straight bayonet-pointed needles. Silk is an animal structure, but must be pure, as shown by its complete solubility in caustic potash; if any residue is left in this solution it contains linen. That such ligatures will disappear from the pedicles of tumors, etc., in time, has been proved by subsequent examinations; occasionally sinuses will form from the death of a ligature. The abdominal cavity is to be washed by a stream of water; clots, etc., are thus coaxed out of every corner, and oozing from adhesions is arrested. The after-treatment is usually uncomplicated, except in hysterectomies, which may go wrong five or six weeks after an apparently successful operation. The patient is not allowed to swallow anything for twenty-four hours, except, perhaps, a teaspoonful of warm water now and then; this serves to rinse out the mouth and allay thirst. An empty stomach diminishes the tendency to the annoying and at times serious vomiting, and favors absorption of any peritoneal effusion. On the second day a few tablespoonfuls of milk and soda are given. The third is the critical day, and the danger peritonitis, indicated by epigastric distension. Should this condition supervene, a small saline cathartic and a turpentine enema should be given which will carry off the flatus. Distension is all that is to be feared, and can be relieved in this way. The temperature is of secondary importance, the pulse being the great guide, and when it rises to 120 a minute, there is cause for anxiety. Another very important guide is the expression of the face, and anxiety is a danger signal, as is also a talkative tendency after operation.—*Medical Record*, May 3, 1890.

**EXCISION OF THE SUPERIOR MAXILLA.**—J. D. Bryant, after critically analyzing 254 cases of the above operation collected by him, comes to the following conclusions:

1. Excision of the superior maxilla is not a dangerous operation, the death-rate in his table being 14 per cent. in 230 cases in which a single maxilla was removed.

2. Contrary to the general belief, excision of both superior maxillæ is not a specially dangerous procedure. In 24 cases there were no deaths, but in 15 of these the removals were incomplete. Complete removal is five times as dangerous as partial excision.

3. While dangerous hæmorrhage is not frequent in this operation, still its effects are to be feared more than any other result of the operation itself. About 4 per cent. died of primary hæmorrhage.

4. Removal of the upper jaw for the cure of bony and fibrous tumors, and the removal of naso-pharyngeal polypi, is attended frequently with dangerous and fatal hæmorrhage.

5. Ligature of one or both external carotids is a safe and commendable procedure when dangerous hæmorrhage is apprehended as the result of operations on the area of their distribution.

6. Ligature of one or both of these arteries may delay the return and hinder the progress of a morbid growth if it be developing in tissues supplied with blood by these vessels.

7. Ligature of the common carotid, for the purpose of controlling the circulation of the external, is unwise, unsurgical and unwarrantable.—*Annals of Surgery*, May, 1890.

**TREATMENT OF RECTAL PROLAPSE BY EXCISION.**—F. Treves writes to criticize

the treatment in ordinary use for severe and intractable rectal prolapse. This condition is met with in children or in advanced life. In the former it appears to be due to a susceptible reflex nerve apparatus, a feeble muscular control, frequent digestive disturbances, excessive activity of the alimentary canal, a comparatively straight rectum with loose connections and mesocolon, and subject to pressure, as it lies more in the abdomen than in the shallow pelvis. Moreover, the sacrum is quite straight and the prostate small; straining occurs frequently from vesical calculus, phimosis, worms, diarrhoea, scybala, etc.; tenesmus is a common symptom, and this is the age at which intussusceptions occur; the ileo-cæcal opening, where they are so commonly met with, is but an internal anus, that of the small intestine. In the young this is usually a more or less active process, and may be attended by violent symptoms; in the aged, on the other hand, it is usually a passive process. Relaxed tissue, enfeebled muscles, dulled nerve apparatus and prolonged straining, such as are associated with stricture, prostatic hypertrophy, constipation and chronic cough, are its pre-requisites. The prolapse may be of two varieties: *Partial*, in which the mucous membrane is alone protruded, the muscular coat remaining unchanged in position; the loose connection between the mucous and muscular coats allows this to be quite extensive; *complete*, in which all the coats of the rectum are prolapsed, mucous, muscular, and, sometimes, serous. The majority of cases, especially children, will yield to simple measures,—rest, removal of the cause, improvement of the general health, regulation of the bowels, astringents locally, trusses, etc. On the other hand, in the aged it often happens that the condition, although it resists such treatment, does not cause sufficient inconvenience to warrant more active surgical interference. Three cases treated by operation are cited: 1. Male, 37 years of age, with prolapse of eleven years' standing, due to chronic diarrhoea. Reduction was difficult, defecation distressing, and had obliged him to give up his business. The protrusion was five inches long, could be reduced with difficulty, and reappeared as soon as the pressure was stopped. The mucous membrane within the lumen of the prolapse was grasped by tongue forceps and drawn down, showing the real apex and preventing recession. An incision was then made at the muco-cutaneous junction, and the mucous membrane dissected off and turned down like a cuff. It was amputated at the level of the anus, the cut edge being caught by pressure-forceps, and the bleeding points tied with catgut. This was then stitched to the skin with silkworm-gut. Recovery was slow, but the prolapse was completely cured. About one inch of the external sphincter was excised and the ends united, as the resulting anal orifice was very large, admitting four fingers. The author considers the procedure useless and it was followed in this case by tenesmus and pain. (2.) Female, 43 years of age, prolapse of 20 years' standing, which had been operated several times with the cautery without avail. The condition, operation and result were similar to the preceding case. (3.) Male, 36 years, with "complete" prolapse of four years' duration. The mucous membrane was dissected off as in the former cases. The protrusion was then hard, except anteriorly, where it was flaccid and the peritoneum evidently present. The buttocks were raised to cause recession of the intestines and the prolapse cut across at the level of the anus or the base of the protruded cone. The peritoneal opening was plugged and the two serous surfaces accurately united. The balance of the amputation after the hæmorrhage was arrested, mucous and muscular coats were united by deep sutures to the skin and subcutaneous structures. Recovery was complete and without complication. The author draws the following conclusions: Subcutaneous injections of ergotin, nux vomica, or carbolic acid need to be frequently repeated, are very painful, cause spasm of the sphincter and are occasionally fatal. Nitric acid applications are relics of barbarism; they cause excessive pain, sometimes extensive sloughing, severe inflammation, or fatal hæmorrhage. A cure, if it result, is at best very slow. (3.) The cautery and clamp are painful, excite at times severe inflammation and may result in excessive cicatrization. (4.) The above-mentioned methods, therefore, are clumsy, uncertain, unsafe and painful. (5.) Excision leaves a smooth bowel end, instead of a burnt or gangrenous surface; hæmorrhage can be controlled, stricture is not to be feared and healing is rapid and complete.—*London Lancet*, March 1, 1890.

**THE QUESTION OF WHAT PRODUCES AND WHAT PREVENTS ANKYLOSIS OF JOINTS**—In a series of experiments recently conducted by Phelps he endeavored to determine the question of whether prolonged fixation of a joint would result in ankylosis. The teachings have been that when normal joints have been immobilized for a longer or shorter period, ankylosis invariably results, and consequently

that motion is necessary to preserve the normal integrity of a joint. Rest being one of the first principles in the treatment of diseased conditions, it seems as though the exception made in joints was inconsistent. Therefore the author was led to make the following experiments: Four dogs were selected and their limbs immobilized. The difficulties to be overcome in experiments of this kind are apparent to all, dogs not bearing confinement well in a cramped and unnatural position. This difficulty however was overcome in a way presently to be described, so that the author succeeded in keeping one dog six weeks; one three months and a half; and two five months, lacking one week. The animals having been etherized the limbs were carefully wrapped with cotton batting, over which a roller and plaster of Paris bandages were applied, the legs being held in a straight position until the plaster hardened. The body of the dog was now similarly dressed and a few turns made to include the legs and draw them well up. In three of the dogs the front legs were immobilized and in the other the hind leg. On examining the joints, all excepting one were found in a perfectly normal condition, and in that one, owing to pressure, a congested spot was found on the head and corresponding portion of the acetabulum; the synovial membrane, however, was normal. These experiments lead the author to the following conclusions: (1.) A normal joint will not become ankylosed by simple immobilization for five months. (2.) Motion is not essential for the preservation of the normal histological character of a joint. (3.) When a healthy joint becomes ankylosed or its histological character changed, it is not due to prolonged rest, but to pathological changes. (4.) A joint immobilized so as to produce and continue intra-articular pressure will result in destruction of the articular surfaces. (5.) Muscular atrophy will follow prolonged fixation of a joint. If these experiments have proven that prolonged rest will not produce ankylosis of a normal joint, that motion is not an essential for the preservation of its normal function, then the cause of ankylosis must be dependent upon pathological changes and not upon prolonged immobilization.—*New York Medical Journal*, May 17, 1890.

**OPERATION UNDER HYPNOTISM.**—E. L. Wood, of Minneapolis, reports an interesting case of osteo-myelitis, in which a necrotomy was performed without the slightest pain. The patient was hypnotized some six times previous to the operation in order to get him under good control. On the morning of the operation, he was hypnotized in bed, and then led to the operating-room. The several existing fistulæ were explored, and an incision, some four inches in length made, after which a large portion of the bone was removed with the mallet and chisel. The operation was done under antiseptic precautions and dressed antiseptically. He was then taken back to bed, and told that he could have something to eat in a few hours. He remained in a cataleptic state until his meal time, when he sat up and requested his dinner.—*Medical Record*, January 4, 1890.

**ETHER ENEMATA IN INTESTINAL OCCLUSION.**—Dr. Clausi gives an account of two cases of intestinal occlusion cured by enemata of sulphuric ether, all other means having proved unsuccessful. The following is the author's mode of procedure: Having dissolved ten grammes of ether in alcohol, add three hundred grs. distilled fennel water. A rubber tube is now introduced as high up the rectum as possible, and then the fluid is injected with an ordinary syringe. The patients experience a sensation of heat, which is diffused over the entire abdomen; almost immediately following the injection they had returns from the stomach with the characteristic odor of ether. A short time following the injection, large evacuations of fecal matter took place, after which the colicky pains subsided. The author was led to the use of ether by its physical and physiological properties which are to excite peristalsis, an essential condition to overcome occlusion. This is either because it excites the terminal filaments of the motor-nerves of the intestines directly or, because its point of ebullition being 35° C., the internal temperature of the body, the ether passes rapidly into a state of vapor, thereby suddenly producing distension of the gut.—*International Journal of Surgery*, May, 1890.

**THE IMPORTANCE OF WASHING OUT THE PERITONEAL CAVITY AS A MEANS OF SECURING A NATURAL DISPOSITION OF THE INTESTINES AFTER LAPAROTOMY.**—Malcolm, in an interesting article, again calls attention to the importance of irrigating the abdominal cavity, as simple paralysis may result, though no peritonitis be present, and, as raw peritoneal surfaces are apt to unite, there is the constant danger of adhesions forming. It is impossible to so arrange the coils of intestines that they will not at some time become adherent. In sponging, they are apt to be disturbed

and thrown into unnatural relations, whereas, by irrigation, they float upward and so undo any twists that may have formed. If the fluid be now withdrawn by means of a syringe instead of sponges, the intestines settle down in their natural position, just as when ascitic fluid is removed. The important point to be remembered, is that it is not so much the fact of the intestines forming adhesions, as it is that they become adherent in unnatural positions.—*London Lancet*, January 11, 1890.

**TREATMENT OF BURNS BY IODOFORM.**—Schiff indorses the treatment introduced by Mosetig Moorhof, consisting of covering the burn with a layer of iodoform gauze. It rapidly relieves the pain, prevents the formation of irregular and contracting scars and, possessing the special advantage of not having to be removed repeatedly, it may be allowed to remain for one or two weeks. No toxic effects need be apprehended from absorption of the drug.—*Monatschrift für Praktische Dermatologie*, 2, 1890.

**TREATMENT OF TETANUS.**—Baccelli uses injections of one centigramme of carbolic acid, repeated hourly. By means of this he cured a severe case in 1887, and at present is treating another in the same manner with marked improvement, so that recovery is beyond a doubt.—*Centralblatt für Chirurgie*, 14, 1890.

**THE RATIONAL TREATMENT OF FLAT FOOT.**—After discussing the etiology and pathology of flat foot, Whitman proposes the following plan of treatment, the object of which is: (1) to replace the dislocation; (2) to hold the foot in proper position; (3) to strengthen and support the muscles; (4) to avoid the original exciting cause by cultivating a proper walk. He divides the treatment into two classes, (1) where the foot can be replaced into the normal position; (2) where the dislocation is accompanied by muscular spasm, or, in cases of long standing, by permanent changes in the bones or soft parts. There should be no routine, each case being judged upon its merits. The author believes that in most instances the over-stretched, weakened muscles and ligaments may more easily regain their tonicity by the use of proper support, while, in the milder forms, simple exercise to strengthen the muscles with the insistence on a proper walk with proper shoes may be all that is necessary. Thomas's treatment, consisting of building up the inner side of the shoe, especially in weak-ankle cases, is a useful aid, tending, as it does, to throw the weight of the body on the outer side of the foot. It is a rather ungainly, triangular splint which tends to interfere with the free flexion of the foot. This method is inefficient in the treatment of the second class of cases, it being simply impossible to expect a working man or woman to go home and take gymnastic exercises, or build up the shoe with the expectation of a resultant cure. Here we have to deal with a dislocation more painful and disabling than any other dislocation in the body. Here the dislocation must be reduced, if possible, by manipulation, or forcibly, after etherization. After reduction, the foot is placed in a position of varus, and retained by plaster of Paris bandages until the spasm and congestion have disappeared. To obtain retention, the author proposes that a plaster cast be taken of the foot, from which an iron pattern is made; on this a brace of thin, tempered, unyielding steel is moulded; this brace accomplishes its purpose, viz., retention, without discomfort; it aids the patient in assuming the proper walk and does not interfere with the normal movements of the foot or the action of its muscles. It is not detected in the shoe and can be worn by a patient in any class of society or grade of intelligence. Having the foot in its normal position and a means to retain it so, we continue the treatment by strengthening the muscles, as on this depends the ultimate success. To obtain this the patient is taught to walk with his toes in front of his body, and with but little outward divergence. The body must be lifted by a muscular flexion of the foot, which is, by itself, the best possible exercise. In regard to operative treatment, the author believes Ogston's operation meddlesome and needless, as the reported cases have been young people who might have been more easily and quickly cured by other means. Supramalleolar osteotomy seems more reasonable in theory and less harmless in practice, but is unnecessary; and it is more reasonable to apply our treatment to the affected part directly, rather than indirectly by producing bow-legs for the relief of flat foot.—*New York Medical Journal*, May 17, 1890.

**THE PULSE AS AN INDICATION FOR ABDOMINAL SECTION.**—Burford calls attention to a class of cases, those of acute traumatic peritonitis, which go on to a fatal issue without any classical symptoms, fever, vomiting, meteorism and hyperæsthesia.

The pulse is not wiry, but small, irritable and compressible and rises and weakens steadily up to the time of death. Exploratory laparotomy, in such adynamic cases, is on a par with tracheotomy in croup, and should be performed early. If other indications are not present, a pulse, over 120 per minute and tending to rise, should be an infallible guide to action.—*London Lancet*, April 19, 1890.

**PERI-PATELLAR SUTURE FOR FRACTURE.**—Stimson reports twenty-five cases treated in this manner. Silk was used and passed by four punctures, transversely, through the ligamentum patellæ, and the quadriceps tendons and longitudinally, in front of the patella, on each side. It was tied in at one of the lower punctures. The first dressing was retained for a week and then a gypsum bandage applied. Mobility could be recognized in two cases; suppuration resulted twice with consequent ankylosis. In the next extension was perfect and flexion was complete in the majority. All could use their limbs and engage in their usual occupation. The period of observation had been rather too short to decide on ultimate results.—*New York Medical Journal*, May 10, 1890.

**TREATMENT OF FRACTURES OF THE PATELLA WITHOUT OPERATION.**—W. J. Bull advocates the following treatment for fractures of the patella: If seen immediately after the accident, cold applications and a posterior splint are to be used; later, elastic pressure, i.e., cotton and bandage are to be substituted for the former. As soon as the effusion has subsided (two days to two weeks, on an average four or five days), and the fragments can be approximated, a plaster of Paris bandage is applied. The limb is elevated and the upper fragments drawn down and held by a loop of adhesive plaster; the lower fragment is similarly treated, or they are approximated by a simple "figure-of-eight." Tilting upward of the fragments is to be overcome by a pad and roller. The gypsum bandage is then applied over a muslin or flannel one or cotton padding. This can be renewed as it gets loose, and is replaced, at the end of six or eight weeks, by a posterior splint and the patient allowed to walk. For four to six weeks more the splint is worn by day and the thigh and knee vigorously shampooed and kneaded, motion at the knee being scrupulously avoided. Electricity is indicated if there is atrophy of the thigh. At the end of three months the splint is discarded, and the limb bent slightly, this being done while the foot is on the floor. A cane is to be used as a "reminder," and exertion carefully avoided, but the injured knee should not be favored. Weakening of the band of union and the joint call for wiring; stiffness had better be left alone, but if combined with impaired extension, the adhesions should be broken up and the fragments wired. In compound fractures wiring is indicated at once, but it is condemned in simple breaks. Aspiration is apt to fail, as the clots clog the canula, and incision is almost as dangerous as wiring. By such treatment the author obtained satisfactory results in three-fourths of his cases.—*Medical Record*, March 22, 1890.

**BLOODLESS AMPUTATION AT THE HIP JOINT.**—Dr. J. A. Wyeth proposes a new method for hip-joint amputations with a view to avoiding hæmorrhage, the great factor in the death-rate. He reports two successful cases. Two more have been done by other surgeons. After the limb has been emptied of blood, two steel mattress-needles, three-sixteenths of an inch in diameter and a foot long, are inserted, the one just inside the anterior superior spine of the ilium passing about half-way between the great trochanter and the iliac spine, outside the neck of the femur, and coming out just back of the trochanter; the other inside the saphenous opening, through the adductors and emerging an inch and a half in front of the tuber-ischii. The joints are protected by corks and strong rubber tubing is wound around the thigh above the needles. A circular incision is now made five inches below the tourniquet and a cuff of skin and superficial fascia raised to the level of the lesser trochanter. The muscles and bone are then cut across at this point. All vessels are tied. The balance of the femur can now be disarticulated by dividing the attached muscles close to the bone and opening the capsule. If the end of the bone is raised toward the umbilicus and the cotyloid ligament incised posteriorly, air enters the joint and facilitates division of the ligamentum teres. In one case the operation was done in two tempos, the disarticulation being made at the first dressing, seventeen days after the amputation. In this way excessive shock is obviated. In the discussion of the paper objection was made to the transfixing needles, which might wound important structures. The method of Furneaux Jordan, figure-of-eight of the thigh and pelvis was advocated.—*New York Medical Journal*, May 10, 1890.



# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

CONDUCTED BY

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**AGARICUS** affords marked benefit in the delirium of typhoid.—*California Homœopath*, May.

**A CASE OF APIS POISONING.**—Dr. A. W. Reddish reports the case of a woman aged thirty-three years, who had suffered from dysmenorrhœa since puberty, and has chronic inflammation and induration of the left ovary, and who was stung by bees in no less than seventeen places. The first symptoms noticed in consequence, half an hour after being stung, were vertigo, nausea, severe pain in the stomach, partial loss of consciousness and cramps in abdomen, the pain extending to the knees. She drank half a pint of brandy, and then the pain and cramps ceased. Very soon urticaria made its appearance on all parts of the body, and by becoming confluent, soon covered the entire surface. Itching was intense and the skin around the stings assumed a bright red hue. Edema was excessive about the right eye, face, arms and hands. Weak spells came and went, and about 4 P.M. perspiration broke out, and the patient fainted, with pulse 100 beats to the minute and very weak. She soon rallied. The urticaria now left, and a feeling of an awful load or oppression extended from the pit of the stomach, four inches upwards, and to the left of the region of the heart. The joints of the arms became red and stiff, and sharp, shooting pains extended through them. The left arm became motionless. The urticaria disappeared in four hours. Under treatment she gradually improved. On the following morning, the edema had greatly disappeared, but her arms felt sore as if bruised.—*Medical Era*, May.

**DOLICHOS SYMPTOMS.**—Soreness and tenderness of gums, even in teething children. Cough on lying down at night; pain as from a splinter in tonsils.—*California Homœopath*, May.

**STRYCHNIA ARSENICOSA 3x**, is a rejuvenating tonic of great value for convalescents from exhausting diseases.—Dr. Holcombe, *California Homœopath*, May.

**OPIUM IN HYSTERO-EPILEPSY.**—In March, 1889, a twenty-year-old girl was suddenly attacked by falling forward. The attacks recurred daily until she came under treatment, seven months later. They are preceded by a sensation of swelling of the whole body; she then falls forward, has a bluish-red color, and the veins become distended and prominent. After the lapse of about a minute she gets up and complains of a dull feeling in the head and violent thirst. Complete unconsciousness exists during the attack. She has loss of appetite and an anxious excitability that even disturbs her sleep; menses rather too profuse. An examination disclosed the fact that there was nothing abnormal in the fundus of the eye, the heart, or the pelvic organs. She received opium, 200. Four months after receiving the remedy she reported that no attacks had appeared after taking the first dose and that the anxious excitability disappeared at the end of a week. With its disappearance she began to sleep better and her appetite returned.—*Allgem. Hom. Zeitung*, February 27, 1890.

**PARIS QUADRIFOLIA IN HEADACHE.**—Dr. E. H. Linnell says: Mrs. H. complained of severe headache, from which she had suffered constantly for three days. She described it as if a cord were attached to her left eye, drawing it back into her head. *Paris quadrifolia* 2c. relieved at once, and has several times since arrested a threatened attack of the same kind.—*North American Journal of Homœopathy*, May.

**ACETUM LOBELIÆ IN HEADACHE.**—Dr. R. T. Cooper cured his nine-year-old daughter of a bad headache, after it had resisted other remedies for two days, with *acetum lobeliæ* in water. The pain was intense and continuous, and the eyes were dull, with slight strabismus.—*Monthly Homœopathic Review*, May.

**KALI HYDRIODICUM IN CEPHALALGIA.**—Dr. R. T. Cooper, in the British *Monthly Homœopathic Review*, for May, draws attention to the splendid effect of kali hydriodicum in diffused and intense pains in the head in adults, especially where there is great sensitiveness to touch, and where the slightest movement causes pain. "In these cases I have found the 30th dilution to act most satisfactorily. In a case lately treated by me, where a woman had suffered for a year from most persistent headache, a pillule given three times a day of kali hydriodicum 30 brought complete relief almost immediately."

**SOME REMEDIES FOR HEADACHE.**—Dr. H. D. Champlin gives the following therapeutic hints in the management of headaches;

*Cartus grand.*—Headache in vertex as a result of menorrhagia, or the menopause.

*Iodide of ammonia*, 1x.—Headaches of young people growing rapidly.

*Santonine*.—Headaches dependent upon eye-troubles.

*Kalmia*.—Headache coming on in the morning, and going away at night.—*Medical Era*, May.

**CHELIDONIUM IN INFLUENZA.**—*Chelidonium* has proved eminently curative in the lung-congestion and hollow, dry cough, frequently observed as a sequela in the influenza epidemic. Leading symptoms: Agonizing cerebro-spinal pains, followed by pain in the region of the kidneys and bladder, together with sweats and diminished urine.—*Agricola*, *Monthly Homœopathic Review*, May.

**SULPHURIC ACID IN INFLUENZA.**—Dr. Morrison has found *sulphuric acid* an exceedingly valuable remedy in cases of influenza characterized by the following symptoms: The precursory symptoms are malaise, then headache; then come the thickly-furred tongue and feverishness, with nausea and vomiting. The vomiting is, usually, first of food, then of bile, and the fever temperature may rise to 102° or 103° F., within a few hours, though the pulse-rate may be only 84 to 92. The craving for liquids is due rather to the clamminess of the mouth than to a mere desire for large quantities. Nocturnal delirium is common. Most of the symptoms are those of acute disturbances of the gastric organs, and their severity often causes great alarm to the patient and friends.—*Homœopathic World*, May.

**CYCLAMEN AND PULSATILLA COMPARED.**—Cyclamen and pulsatilla are often difficult to differentiate. They are both suited to chlorotic and anæmic women, and they both have some trouble with digestion and intolerance of fatty foods. Both have chilliness with the pains, crying, tearful mood, and menstrual colic. Both have aggravation in the evening, and relief from moving about, but pulsatilla has prominently relief from a cool room or from being in the open air, while the cyclamen patient is worse in the open air. Cyclamen is better indicated in too frequent and too profuse menstruation, with flow of black, clotted blood, while pulsatilla corresponds better to scanty or delaying menses. Pulsatilla has thirstlessness with all complaints, while cyclamen generally, but not always, has thirst as a symptom of the trouble to which it is adapted. The cyclamen patients suffer from a peculiar debility of mind and body. When they awake in the morning they are sleepy and tired; feel so heavy and languid that they can scarcely drag around at first, but when once at work and forced to exercise they feel better. With pulsatilla we find much the same symptoms, but it is especially in the fresh, cool air of out-of-doors that the afflicted woman finds relief from her tired, worn-out feeling. Finally, there is the transient obscuration of vision that is characteristic of both remedies. In pulsatilla, however, the temporary blindness generally appears during menstruation or as a consequence of suppressed menses. In cyclamen the obscuration of sight is more characterized as being accompanied by semi-lateral headache of the left temple, with pale face and nausea referred to the throat.—*Journal of Obstetrics*, May.

**MERCURIUS VIVUS.**—When you meet a child with excoriated patches, like islands, on the tongue, you may suspect difficulty with the stomach, "craving for fat," and mercurius vivus is the remedy.—W. S. G., *Medical Advance*, May.

**REMEDIES FOR DIPLOPIA.**—Dr. H. H. Crippen, in an article in the May number of the *American Homœopathist*, on the "Practical Treatment of Diseases of the Eyes Among Children," mentions the following medicines:

*Remedies having diplopia.*—Acid nitricum, aconite, agaricus, ammonium carbonicum, argentum nitricum, aurum muriaticum, belladonna, cicuta virosa, conium, digitalis, eug. cam., euphorbia, gelsemium, genseng, hyoscyamus, iodium, jaborandi, mezereum, natrum muriaticum, paris quadrifolia, petroleum, plumbum, pulsatilla, rhus toxicodendron, secale, stramonium, tabacum, theridion, thuja, veratrum album.

*Diplopia*, controlled by an effort of the will, gelsemium.

—disappearing on bending the head backwards, senega.

—from mechanical injury to the muscles of the eye, arnica.

—horizontal objects at some distance seem double, acidum nitricum.

—objects seem double and black, cicuta virosa.

—on looking downward, arnica.

—on looking sharply at an object, genseng.

—due to paresis n. abducen. sin., causticum, cuprum aceticum, kali hydriodicum.

—due to paresis n. abducen. dext., sulphur, chelidonium,

—due to paralysis n. oculo. mot. dext., nux vomica.

—due to paralysis n. oculo. mot., sin., senega.

—due to paralysis n. patheticus, senega.

—transitory, aconite.

—when inclining the head to either side; vision single when the head is erect, gelsemium.

—with frequent obscuration of sight, petroleum.

Besides these remedies in a general way, we may indicate: aconite, for paresis, after exposure to cold winds (causticum); euphrasia, with catarrhal symptoms, with blurring of vision relieved by rubbing; mercurius iodatus flavus, for paralysis and paresis of syphilitic origin (kali hydriodicum); phosphorus, paralysis from nervous exhaustion (zincum phosphoricum); rhus toxicodendron, in rheumatic diatheses; spigelia, when associated with superciliary neuralgia.—Dr. Norton.

**GELSEMIUM IN TEMPORARY BLINDNESS.**—Dr. Harmer Smith thus describes his own case, and the method by which he obtained relief: "I have, for more than forty years, been subject to attacks of temporary blindness, especially in damp weather, and after oversleeping myself, although not generally a good sleeper. The attacks used, frequently, to last half an hour or more, beginning with black spots (*muscae volitantes*), followed by dense clouds covering the whole field of vision, leaving for about another half hour a dazed or stupefied feeling, making it difficult to collect the thoughts, also frequent vertigo." Various remedies were taken without relief. During the last few months, I began "to take one or two drops of the mother-tincture of gelsemium immediately on perceiving the premonitory symptoms of an attack, the effect being immediate and complete relief."—*Homœopathic World*, May.

**ROSE DAMASCENÆ IN DEAFNESS.**—Hardness of hearing, with ringing or singing in ears; catarrh of Eustachian tube.—*California Homœopath*, May.

**PHYTOLACCA IN DENTITION.**—The symptoms that indicate phytolacca during the dentition of infants, are: Crying, restless and feverish, especially at night; the teeth are long time coming; wants to bite something hard and feels relieved by it.—Dr. H. D. Champlin, *Medical Era*, May.

**ASCLEPIAS IN MYALGIA.**—Myalgic pains of chest, simulating pleurisy.—*California Homœopath*, May.

**SAMBUCUS IN RESPIRATORY AFFECTIONS.**—Fatigue; every motion causes an almost suffocating shortness of breath, with much perspiration.—*California Homœopath*, May.

**THUJA IN NÆVUS.**—"Jane G., aged six weeks, was brought to me with a subcutaneous nœvus on the left labium majus. The nœvus was about the size of a small hazel-nut, swelled visibly and sensibly when the child cried, and had the usual livid

capillary vessels on the skin over its centre. *Thuja occidentalis* 6 was applied thrice daily for six weeks, at the end of which time the nævus had completely disappeared.—Dr. C. J. Wilkinson, *Monthly Homœopathic Review*, April.

**ACONITE IN EPISTAXIS.**—In the twelfth potency, aconite is the best treatment for the nose-bleeding of children, followed by arnica, if necessary.—Dr. Bayes, *California Homœopath*, May.

**VERATRUM VIRIDE AS AN HÆMOSTATIC.**—Dr. R. T. Cooper, in the *British Monthly Homœopathic Review* (May), states that, in a case of *fungus hæmatodes* of the bladder, marked relief to the bleeding followed each dose of *veratrum viride*, given in the 3x dilution, after various allopathic measures had failed to give relief.

**HIPPOZANIA IN SKIN DISEASES.**—Dr. Morrison, with *hippозania* 12, permanently cured a child suffering from extensive eczema. No other drug was given. It also proved of great service in a case of inveterate rupia.—*California Homœopath*, May.

**REMEDIES FOR TARDILY-APPEARING EXANTHEMATOUS ERUPTIONS.**—There are a few remedies, pointed out by Farrington, that are worth a brief review in their association with tardy appearance of the eruptions of the exanthemata, or with suppression of the rash.

**Bryonia:** Under bryonia the eruption comes out imperfectly, and meningitis follows. The child's face is red, or else it is red and pale alternately. The rash has not the smooth character of belladonna, otherwise there are many symptoms similar to this last-named drug. The child screams out suddenly, apparently with sharp, lancinating pains, and this is especially manifested on moving the child. There is marked squinting with one or both eyes. The bowels are usually constipated, the abdomen distended, and the child has marked sensorial depression, bordering on stupor. With all this benumbing of the senses there are no absolute hallucinations, as under belladonna. The child does not awaken from sleep clinging to those around them, as with stramonium or cuprum.

**Cuprum:** In like cases, suppression of eruption, with consequent affection of the brain, cuprum is the remedy when the symptoms are violent and the characteristic spasms indicating this remedy are present.

**Zincum** is to be preferred if the child is too weak to develop an eruption. The eruption comes out sparingly. The surface of the body is rather cool. The child lies in a stupor, grating its teeth; it starts up during sleep. Squinting and rolling the eyes are observed, and there is marked fidgetiness of the feet.

**Ipecacuanha** is to be thought of when the chest is affected from the recession of the rash of measles, when there is difficulty of breathing, wheezing, rattling respiration, etc.

**Tartar Emetic** ought to be given in preference to bryonia when the disease, in which the eruption is tardy or suppressed, is variola.

**Camphor** may also be of use in suppressed eruptions where delirium, mania or convulsions exist, with the characteristic coldness and extreme prostration.—*Journal of Obstetrics*, May.

**KALI IODAT. IN BRONCHITIS.**—Kafka cured a case of bronchitis with kali iodat. after other remedies failed to relieve. The symptoms were: Constant cough day and night, loud rattling of mucus in the bronchi, very hard to expectorate, much dyspnoea, loss of appetite, slimy taste, tongue coated, stool tardy, urine diminished, of high specific gravity; temperature 100½°, pulse 92, respiration 30, sweating of the forehead, expectoration of mucus mixed with saliva, hard to loosen; disease was caused by walking across a bridge at night; later there developed somnolence, faint feeling and pallor of the skin. *Kali iodat.* 1x brought about almost immediate relief and an ultimate cure.—*Allgem. Hom. Zeitung*, January 9, 1890.

**ARALIA RACEMOSA IN NIGHT COUGH.**—Dr. E. H. Linnell has cured several coughs with *aralia racemosa* 1x, when the paroxysms came on regularly at 11 P.M., after a short nap.—*North American Journal of Homœopathy*, May.

**LACTUCA VIROSA IN SPASMODIC COUGH.**—A lady had frequent paroxysms of violent spasmodic cough, with feeling of suffocation. The attacks came on very suddenly without apparent exciting cause, and were induced by violent tickling in the pharynx and roof of the mouth. *Lactuca virosa* 2c, a few doses, administered one after each coughing spell, soon cured her.—Dr. E. H. Linnell, *North American Journal of Homœopathy*, May.

**RUMEX CRISPUS IN COUGH.**—Dr. J. S. Cardoza reports the cure of a number of cases of cough following the late influenza epidemic, with *rumex crispus* 3, after other medicines had failed. Indications: Dry, teasing cough, very troublesome during the day, none at night (*euphrasia*), cough did not start until late in the morning, and was bad in a warm or cool room, in the house or open air, and remained confined to the larynx, and was more teasing and annoying than harassing.—*American Homœopathist*, May.

**CIMICIFUGA IN RHEUMATIC THYROIDITIS.**—Dr. Irving Townsend reports the cure of two cases of rheumatic thyroiditis with *cimicifuga*.—*North American Journal of Homœopathy*, May.

**BROMINE AND CARBO ANIMALIS COMPARED IN MAMMARY CANCER.**—Bromine is not often thought of in cancer of the mammary gland, but after careful study we have been testing it lately, and find that it is sometimes useful. It requires careful comparison with *carbo animalis*, since both remedies have, quite markedly, induration of the axillary glands with burning pains. The breast is hard, and on palpation a dull, subdued sort of throbbing may be felt in it. Farrington says of the cutting or drawing pain of bromine, that this symptom is so marked that it feels as if a string were pulling from the gland into the axilla.—*Journal of Obstetrics*, May.

**ERIGERON IN TYMPANITES.**—Erigeron is the most valuable remedy for tympanites; internally and locally in enemas.—*California Homœopath*, May.

**TREATMENT OF TYMPANITES—*Nux Vomica*.**—The abundant production of flatus is a physiological effect of *nux vom.*; incarcerated flatus; there is painful tympanites and borborygmi. This drug is especially indicated in the tympanites with intestinal occlusion (6x); it has, however, given successful results in hysterical tympanites (φ). The principal indications for *nux vom.* are: Excessive pain, vesical tenesmus, complete suppression of stools, and flatus.

***Colocynthis*.**—Indications almost similar to those of *nux vom.*; the tympanites is more painful, with continual borborygmi; with tenesmus and incarceration of flatus. Dose—low dilutions, and repeatedly.

***China*.**—Tympanites is a constant symptom of *china*. It may be excessive, with borborygmi and complete retention of flatus. In this drug tympanites is associated with enteritis. It is especially indicated if abdominal pains come immediately after taking food; more so in case tympanites is associated with diarrhœa, when stools are provoked by the same circumstances. Dose—low dilutions.

***Lycopodium*.**—Tympanites associated with borborygmi and cold feet; especially indicated in the dyspepsias with flatulence and constipation; the tympanites of hypochondria is favorably modified by this drug. Dose—30th dilution mostly employed.

***Belladonna*** is the principal remedy in the symptomatic tympanites of intestinal occlusion; tympanites associated with borborygmi and retention of flatulence; mostly painless, though sometimes it is extremely painful. More than in any other tympanites, the intestinal motions can be seen through the abdominal walls. This drug has often given me good results in intestinal occlusion, but failed, even in large doses, in a case of hysterical tympanites. Dose—1st triturations and φ.

***Chamomilla*.**—This is a traditional medicine in the treatment of hysterical tympanites; produces excessive distension of the abdomen with pressure in the groins, raise of epigastrium, difficulty in respiration, and very noisy borborygmi. As accessory, and very important symptoms, we find an anxiety carried to despair; principally the redness of face in one of the cheeks. Dose—from the 6th dilution to the φ.

***Opium*.**—The tympanites with this drug is produced by intestinal paralysis; thus it has given happy results in intestinal occlusion. Its characteristic is a considerable tympanites without any peristaltic action, and consequently without borborygmi. Dose—1st dilution.

***Taraxacum leontodum*.**—The indications of this plant are still entirely empirical; I have found it mentioned in a thesis written in the beginning of this century, and have prescribed it several times with success in the treatment of hysterical tympanites, and, particularly, in an extremely grave case where in a previous attack intestinal puncture had been performed. The dose I then used was three drops of the mother tincture in six spoonfuls of water, a spoonful every fifteen minutes. Amelioration followed after the second spoonful and produced an enormous evacuation of flatus, which ended the tympanites.

***Intestinal Puncture*.**—This is indicated when difficult respiration shows danger from

asphyxia. The antiseptic measures avoid any danger in this operation. I have performed intestinal puncture with great success in hysterical tympanites.—Dr. Pierre Jousset in *L'Art Médical*, May, 1890.

**SECALE AND ARSENIC COMPARED IN DIARRHŒA.**—In the diarrhœa of children, secale, like arsenic, is indicated by profuse, undigested stools, which are watery and very offensive, and produce intense prostration. But there is always the great distinction, that, under secale, the patient wants to be cool, while the arsenic patient wants to be wrapped up warmly.—*Journal of Obstetrics*, May.

**CHELIDONIUM IN CONSTIPATION.**—In chelidonium we have a remedy for constipation, proceeding from hepatic torpor, unapproached by any other one drug in the whole materia medica.—*Agricola, Monthly Homœopathic Review*, May.

**BERBERIS IN NEURALGIA.**—A writer, in the May number of the *British Monthly Homœopathic Review*, reports the cure, with berberis 3x, of a woman, whose disease had been variously diagnosed as rheumatism, dyspepsia, and neuralgia of the bowels. Symptoms: Each attack comes on suddenly, without any premonition with a violent pain in the region of the right kidney, passing gradually over the crest of the ilium and terminating abruptly in the right supra-pubic space. At the acme of attack, she bent double and shrieked in the agony of her suffering. After the termination, she passes a large quantity of bloody urine. In the intervals, she complained greatly of weakness; mouth constantly full of a sticky, bad-tasting saliva; tongue coated yellowish; a sense of weight in the hepatic region; constipation, stool hard, every three days; yellow, muddy complexion.

**CEPA IN DYSURIA.**—For frequent urging to urinate; the urine passes by starts or only in drops, is bright-red and burning. For children when they scream, particularly when you press upon the region of the bladder; after a cold or exposure of abdomen to cold air or draught.—*California Homœopath*, May.

**DIOSCOREA IN WHITLOW.**—In the 12th and 30th, *dioscorea* has proven very serviceable in mitigating the pain of suppurating whitlow.—*California Homœopath*, May.

**JACARANDA IN VENEREAL SORES.**—Jacaranda, a South American plant, introduced by Muir, has been recommended as an excellent remedy for chancroid-like sores about the external genitals.—*Journal of Obstetrics*, May.

**REMEDIES FOR WARTY GROWTHS ABOUT THE GENITALIA.**—We summarize briefly indications for some medicines for sycoësis and condylomata of the genitalia from the May number of the *Journal of Obstetrics*.

**Thuja.**—Condylomata on the vulva, perineum, about the anus, and even on the mucous surfaces of the internal genital organs. The warts have a seedy look, or they may be of a cauliflower shape, deeply fissured. (When affecting the cervix, they are especially apt to take this last condition.) Thick, greenish leucorrhœa; warts that are moist and ooze a glutinous fluid. Sometimes ulcers about the vulva and adjacent parts, which bear many of the appearances of chancroids; they have a dirty yellow base, with hard edges. Ulcerations originating in warts.

**Kali bichromicum.**—Ulcerations affecting the vulva in sycoëtic constitutions. These ulcers extend deeply rather than superficially, have a hard base, and a red and inflamed areola. There is an accumulation of tenacious discharge about the genitals.

**Nitric acid** approaches very closely to thuja in condylomata of the vulva. It has also moist fissure at the anus, as under thuja, and greenish leucorrhœa. It may be distinguished by the aching pains in the bones, especially in those localities devoid of muscular tissue covering, as along the tibia.

**Staphisagria** suits long filiform condylomata. Crumbling teeth and eczematous eruption, with the formation of yellow scabs.

**Sabina.**—Condylomata which itch and burn.

**Euphrasia.**—The condylomata look like a cock's comb.

**Cinnabaris.**—Fan-shaped fig-warts.

**Sarsaparilla.**—Moist eruption about the genitals.

**Petroleum.**—Moist eruption about the genitals; "membranous shreds about the anus."

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ADDRESS BEFORE THE BUREAU OF OBSTETRICS.

BY T. GRISWOLD COMSTOCK, M.D., OF ST. LOUIS, CHAIRMAN.

(Read at Forty-third Annual Session of the American Institute of Homœopathy.)

*Gentlemen of the American Institute, Members of the Bureau of Obstetrics:* I am glad to meet you and greet you at this, the annual session of the Institute. I take this occasion to express my feelings of gratified pride for the honor you have conferred upon me in your selection of a chairman. You have imposed upon me a pleasant duty.

I am sorry to inform you that your last presiding officer, Prof. Sheldon Leavitt, will not be present with us this year. He is absent in Europe in the interest of the profession.

The Bureau of Obstetrics is one of the most important of all the sections of this Institute. The practice of midwifery is coeval with man, the most ancient of all the arts in medicine; and as regards practice, it is the most important portion of it. When we see a vast multitude of human beings assembled together anywhere in the world, does not the reflection occur to us that each and every one of that number was "born of a woman," and has occasioned pain and sorrow to a mother? Until the end of time the practice of midwifery will require the earnest attention of the physician, and in view of this, is it not strange that in modern times the profession gives so little special attention to obstetrics? It would seem that the enthusiasm and patient study of the best men of our profession were being exhausted upon gynecology. Look through our best

medical journals, and you will find numerous painstaking articles upon gynæcology, and especially upon capital operations connected therewith, but scarcely a single paper upon obstetrics. Is not this remarkable in view of the fact that most of the affections that fall to the lot of the gynæcologist to treat are caused by troubles connected with child-bearing?

I think you will bear me out in this statement; and if such is the case, the obstetric art needs to be carefully studied, so that we may prevent after-affections so frequently met with in practice. It would seem, therefore, the duty of every one in our profession to master the obstetrical art before they presume to announce themselves as gynæcologists. One reason why medical men try to avoid the responsibility of the practice of midwifery is most probably that they do not like the confinement which is necessary in attending a woman in labor.

To be a successful practitioner of midwifery, the physician must be sufficiently self-denying to "scorn delights and live laborious days." He has to give up every other case that he has to attend, and devote his whole time to the parturient patient, until the delivery is completed. In earlier times midwifery was only practiced by women, and our sex was prohibited from crossing the threshold of the lying-in chamber. Such was the case until about the middle of the sixteenth century. Even so late as 1522, Dr. Wertt, of Hamburg, was burned alive because he disguised himself as a woman and attended a case of labor. Have we not much to be thankful for in the change that has come in less than three centuries? Is the practice of midwifery as popular with our best physicians as it was thirty years ago? We can all answer in the negative. In a recent number of one of our best medical journals is a leading article with this heading: "The Decay of Obstetrics." It justly terms midwifery as "the vertebral column of general practice." It laments that "at large meetings of practitioners there is always a scarcity of papers upon a subject so important as obstetrics, while the columns of medical journals teem with the sayings of gynæcologists, both great and small." I think that I see already some slight signs of the revival of obstetrics. During the past year several interesting articles have appeared in our journals upon occipito-posterior positions in labor and the importance and serious nature of this vicious position is freely conceded. Prof. Sheldon Leavitt has contributed to this bureau an exhaustive article upon this subject.

It is admitted that in about 4 per cent. of such original positions



the occiput fails to rotate under the pubes, and then delivery has to be effected by flexion instead of extension, with a great risk to the perineum. A year ago, in a paper that I read before your section, the operation of episiotomy was recommended in such cases, to save the perineum. The bureau did not unanimously endorse my recommendation. The operation, although frequently practiced on the Continent of Europe (especially in Germany, where I first met it years ago), is not to be inconsiderately resorted to. I extract the following from the most recent work that has appeared upon midwifery. I refer to Winckel's great work on midwifery, translated from the German by Prof. Clinton Edgar; issued January, 1890. In describing episiotomy (or incision of the introitus vaginæ), he says:

"An incision into the external genitals, to prevent an impending laceration of the perineum, was first performed by G. Ph. Michaelis, in 1799, at Hamburg."

[But Sir Fielding Ould, of Dublin, in 1742, gave a full account of the indications for this operation—preceding Michaelis by nearly sixty years.]

Winckel further remarks:

"The threatened destruction of the perineum is the only indication for episiotomy; this danger may be due to extreme narrowness of the external genitals or to excessive rigidity of the soft parts or to a faulty presentation of the child. It is done to prevent extensive solution of continuity, especially central rupture. The performance of this operation is easy and simple. It can be done either in the back or side position of the parturient, and is but slightly painful. The use of a herniotomy knife is not essential; an ordinary, straight, blunt-pointed pair of scissors, or, occasionally, straight, sharp, navel-string scissors, answer the same purpose.

"I make the incisions only during a pain, when I see the epidermis at the fraenum, or at the middle of the perineum, beginning to tear."

A friend of mine, recently from the obstetrical clinic in Vienna, informs me that episiotomy is now frequently performed there to prevent lacerations. I first learned it in Braun's wards, long ago, and for years past I have occasionally practiced it to save the perineum. It has satirically been styled "the young practitioner's operation," but it might be more properly termed the accomplished practitioner's operation.

Many papers have appeared the past year upon ectopic gestation. Several plans of treatment have been recommended. They may be summarized as follows: Electricity has been proposed to be used, not after the third month of conception, to destroy the fœtus. Galvanism has been tried, but found unsafe, and the Faradic current has now been adopted as the best means. In Germany, injections of drugs (morphine, even strychnine) seem to be the favorite method to destroy the fœtus.

When the foetal heart is distinctly heard, after the fourth month, laparotomy is the best method. Such cases require the greatest care, observation and solicitude of the obstetrist, as the diagnosis is by no means easy or certain, and the question as to their treatment is still somewhat in doubt. Each case must be individualized, and the proper homœopathic remedy be given, and then it may be often left safely to nature, until no doubt remains as to the existence of a dead fœtus, when, in my opinion, laparotomy is the only resource. Some cases that I have known, where the diagnosis was doubtful, have been treated entirely by homœopathic remedies, and the untoward symptoms all disappeared.

*The Forceps.*—The doctrine taught by our forefathers in midwifery (viz.: Ramsbotham, Churchill, Blundell, Bœer, etc.), was that they "should not be resorted to until all the powers of life were exhausted, all capacity for further exertion at an end and the *mind as much depressed as the body*, so that they would both sink together unless rescued by art!" Such a doctrine was the rule when the Princess Charlotte of Wales, in 1817, was fifty-two hours in labor, and was finally delivered of a dead child, and then expired. The court obstetricians who attended her were afraid to apply the forceps because the rules in the books were against such interference; and one of the medical attendants, Sir Richard Croft, subsequently committed suicide from chagrin at the loss of his patient.

What changes have been wrought in less than seventy years! Churchill, in England, gave the statistics of the use of forceps at 120 in 42,196 labors, or 1 in 351; in France, 1 in 162, and in Germany, 1 in 153. How is it now? We all know that the forceps is the child's instrument, to save its life and to end the pains of the mother. One of our most celebrated practitioners, a resident of Little Rock, told me the other day that he used the forceps in about 1 in 3 cases of midwifery. In my own experience I can scarcely give statistics, but I use them at least 3 times in from 15 to 25 labors.

I may sum up the indications for their use: When the mother is

in feeble health, or so weak that she cannot bear down, and the labor is protracted ; or, when either mother or child runs any danger from the labor being protracted, and *this danger will cease when the labor is ended, the forceps are indicated.*

The forceps, when properly used, cannot do any harm ; and moreover the modification of Tarnier, in adding what he calls traction-rolls, attached to a point in the lower curvature of the blades, so as to avail ourselves of the principle of axis-traction, is an improvement, and adds to their value in some special cases. But while Tarnier's forceps, as I have said, possesses some advantages in certain cases, it will never supersede the old forceps.

With the march of experience, the indications for craniotomy are being lessened every year ; and the Porro-Cæsarean section is already being recommended as a substitute in all cases where the child is not dead. The Porro operation, as you are aware, is simply a supra-vaginal hysterectomy ; only the uterus contains a child, instead of a fibroid tumor. In a recent address in the London *Lancet*, it is stated that sixty years ago the mortality of the Cæsarean section was from 70 to 90 per cent., and now, under the improved method of operating, with antiseptics, the mortality is, in Dresden and Leipzig, reduced to less than 10 per cent.

From reports in Great Britain, of the results of the Porro operation, for four years ending April, 1899, the mortality is given at 19 per cent., and for the Cæsarean section (Sanger's operation) the mortality was 25 per cent. I may safely assert that it is now conceded that the Porro operation, skilfully made, is safer for the mother than the old Cæsarean section.

A recent authority, Dr. R. Barnes, asks the following question : "Ought craniotomy be performed upon a living child ?" He adds : "This question has stirred the consciences of physicians even to the most recent times." I confess that with a large clinical experience, personally, I do not hesitate to advise the Porro operation, as a substitute for craniotomy, if the child is alive.

The subject of the pathology of puerperal fever is not yet settled. The majority of modern writers regard it as a local disease—being nothing less than a surgical or septic fever. Others, and myself with this minority, regard it as an *essential* fever, or a zymotic disease, the result of some peculiar and unknown poison. Robert Barnes says :

"We must therefore understand puerperal fever as fever in the puerpera, and abandon the vain attempt to find only one definite puerperal fever, but recognize the clinical fact that there are puerperal fevers."

In this view of the case, I freely concede that the origin of puerperal fever is a puerperal poison; but I conceive that there are two forms of it—one an *essential* fever, from an autogenetic or endo-septic cause, and the other exhibiting itself as a local disease (septicæmia), from a heterogenetic cause.

The subject of antiseptics in labor deserves more than a mere mention. It should never be ignored nor neglected; because we have the fact before us that by the aid of antiseptics, abdominal surgery has been brought to a perfection and success that could never have been attended by any other means. Cleanliness in the confinement chamber is the first and best antiseptic, but this is not quite all.

One fact should be well understood, that, theoretically and practically, by the use of antiseptics it is intended to *prevent* the introduction of germs, rather than the destruction of microbes. It should be the duty of the accoucheur to see that neither himself nor the nurse shall be the means of carrying anything about them that can convey infection in any manner.

In case the nurse has been recently caring for any patient with a disease that was contagious, she should not come into any confinement room. The accoucheur, if in attendance upon a case of scarlatina, diphtheria, typhoid or puerperal fever should not attend any new confinement case until he has been disinfected, and has ceased to come in contact with any such patient.

I need not mention the particulars required to carry out a rational system of antiseptics in the confinement room and during convalescence, for you are all familiar with the same.

I desire, however, to call attention to a new remedy that is antiseptic, relatively harmless, and in all respects believed to be equal to corrosive sublimate. It is creoline, one of the coal-tar products. It has been used in the Munich hospitals to the exclusion of other antiseptics. I have used it for the past eighteen months, and can speak highly of it. It is as good as sublimate, and we gain a great advantage, as we avoid the dangers of the latter. It mixes with water, forming a sort of milky emulsion. It should be used locally in obstetric practice, in the strength of a teaspoonful to a pint of water.

One little matter I have attended to for the past ten years, and that is to require all my patients to be confined upon tarred paper, spread upon the mattress, and as soon as the delivery was over, this has been thrown away, and the patient had a clean sheet and mattress. For a year past I have used a new *accouchement sheet*, made out of *wood wool*. This is something recently imported, and comes in the

form of a sheet of soft wool, large enough to cover the confinement bed. It is soft, and of the thickness of two comforts, is antiseptically prepared (by sublimate), is inexpensive, costing about fifty cents, impervious to water, and is absolutely the best absorbent known; and after delivery may be thrown away or burned. This antiseptic wood wool also comes to us made up into diapers, that cost *less than the washing of ordinary diapers*. After use, each one may be thrown away or burned.

This wood wool may be utilized as a dressing for the navel cord, and we have thus employed it, after the recommendations of physicians on the continent.

During the past year I have heard of a case of puerperal fever supposed to have resulted from a gonorrhœa contracted by the parturient during her pregnancy.

I stated in a paper last year, that gonorrhœa in women is far more costly to life and health than syphilis. The treatment of ophthalmia neonatorum in children of women afflicted with either latent gonorrhœa or uterine catarrh, was discussed in a paper read before the Missouri Institute of Homœopathy, at Springfield, by Professor J. A. Campbell, of St. Louis. He mentions Crede's treatment, in use all over Germany, of lapis infernalis, 2 per cent. solution, dropped into the eyes of the child immediately after birth. Dr. Campbell recommends boric acid solution, 10 grains to the ounce. Others have recently employed corrosive sublimate, solution 1-4000, for the same purpose.

The statistics of lying-in hospitals, where careful antiseptic rules are carried out (and this means cleanliness and fresh air), exhibit to us more favorable results than can be furnished in private practice.

This is something that will give us food for reflection: I have seen it stated, a year since, that in the Tarnier Pavilion, in Paris, they had nearly one thousand deliveries without one death; and in 1888, in the Queen Charlotte Lying-in Hospital, in London, there were nine hundred and sixty-three confinements with only two deaths. In Preston Retreat, in Philadelphia, they have had over eight hundred cases of confinement and not one death. My authority for this is a letter from Dr. Price, physician in charge of the Retreat—date of the letter, May 27, 1890. In his statistics of the first five hundred labors, the forceps were used fifty-two times.

The great success of this treatment is due to the "strict enforcement of the law of cleanliness"—the best of all antiseptics. This is a most excellent showing, and cannot be paralleled by the sta-

tistics of any foreign institutions. It may be accounted for, because in *maternities* every appliance is at hand, for not only the most skilful treatment of the puerperal woman, but likewise for her care and nursing, until until she is discharged convalescent.

Brow presentations are still fraught with difficulties, and the prognosis of the same is less favorable than face presentations. In their treatment by extension they may be converted into face presentations, or by flexion into vertex presentations. One case occurred in my experience the past year (it was a consultation), where there was an impaction of the head in mid-pelvis, and the forceps could not be applied. Craniotomy was resorted to after there was every indication that the fœtus was dead.

Lacerations of the perineum (where they extend for an inch) during labor, should be operated upon immediately after delivery, and such treatment seems now to be almost unanimously recommended by the best authorities.

*Eclampsia*.—The prognosis of convulsions complicating labor is still grave. They are always more serious when they commence early in the labor, before the birth of the child. A paper upon this subject was read by Dr. O. S. Runnels, ex-president of the American Institute of Homœopathy, at the meeting of the Missouri Institute of Homœopathy, held in St. Louis, in April last. His paper was an exhaustive one. He emphasizes the premonitory symptoms of headache, visual disturbances, and epigastric pain. He states that although the disease has been characterized as an albuminuria, that at least one-fifth of the pregnant women have albuminuria without having any vestige of the disease. Some years ago, Carl Braun, in Vienna, said that when patients with eclampsia had but little albumin in their urine the prognosis was not so good as when it contained a good quantity. This seems paradoxical. We all know that albumin is found in the urine of a certain proportion of pregnant women, and that it frequently occasions them no harm. Dr. Fordyce Barker estimated that about one pregnant woman in twenty-five has albuminuria, and obstetrical statistics show that eclampsia happens once in four hundred and fifty labors. If, now, only four per cent. of these four hundred and fifty women have albumin in their urine, and only one of them has eclampsia, then we may dismiss the old theory, as taught us by Professor Frerichs, that albumin causes puerperal convulsions. It is now the received opinion of the best observers and clinicians, that eclampsia is caused by the suppression of natural evacuations, both fœcal and urinary, or from the absorbed products

of internal putrefaction. What gives currency to the belief is, that women thus afflicted suffered from an unnatural constipation during the period of their gestation.

Dr. Runnels advises the indicated homœopathic remedies; but, in addition, if convulsions come with great frequency, he says *sedatives* must be used—chloroform, hydrate of chloral, and veratrum viride—the latter used hypodermically. Winckel, in a most positive manner, rejects the old allopathic remedy of blood-letting. He says, it cannot allay the weakness of the heart, but rather increases it. He also rejects the more recent allopathic remedy, pilocarpine; objecting to it because it is too depressing; and both remedies are stricken from the list. He gives every pregnant woman who has albuminuria aloes and colocynth before labor; and, with warm baths as adjuvants, claims to prevent the accession of the convulsions.

For some years I have fortunately had no case of eclampsia, and I hope that by careful homœopathic treatment I may have prevented them. I still, however, admit it to be among the gravest affections that the accoucheur has to deal with. Corrosive sublimate, recommended as a specific, has been tried by some practitioners—one, a physician of my acquaintance—in minute doses hypodermically, especially for puerperal convulsions of the hysterical kind. With this I have had no personal experience.

Chloroform, as an anæsthetic in labor, is employed by many obstetrists of our school. In my own practice, I have for many years past only used it in exceptional cases—occasionally in the last hours of very painful labor, when the second stage of labor is nearly completed. In operations of a painful nature I use it—not in ordinary forcep cases, but when the application of forceps is difficult, and there is delay in delivery, it may be given. In France and upon the Continent, hypnosis is recommended as a substitute for chloroform, and it is said to be entirely successful in alleviating the pains of labor. In such cases we are told that it is best for the practitioner to hypnotize his patient a short time before the labor, in order to be sure of success when the labor pains come on.

While writing this address, I met one of our best practitioners, a professor in one of our St. Louis colleges (old school), and he related two cases of labor in his experience where hypnotism was practiced with perfect success, so that, by means of *suggestion*, the labor went on normally until delivery was accomplished and the patients were unconscious of any pain.

I believe in the reign of law and the survival of the fittest, but

this is a matter that should be carefully studied. Some of my friends may think its very mention is inopportune, and that it should never be even thought of in obstetrical practice. Psycho-therapeutics is, however, gaining ground, and we know that it has been used in convulsions (not puerperal) with success.

The great mathematician, Arago, said: "As soon as one is concerned with the living organism, caution becomes a duty; but he who uses the word *impossible* without the sphere of pure mathematics is at least careless." While I do not care to take any extreme position on the subject of hypnotism, I am sure it is important for each of us to give it a most careful and thorough investigation.

The astonishing results already demonstrated fill us with wonder, and urge us to further and careful research. A great deal is yet to be learned in regard to mental operations in the cure of disease.

To a true physician nothing is unworthy of regard which offers any hope of helping suffering humanity.

I have touched in this address upon only a few practical points, and I beg your forbearance. If I have exhibited too much enthusiasm, I trust you will be at least lenient. I cannot bring these remarks to a close without taking the liberty to express the hope that our school will exhibit a new characteristic enthusiasm and industry in cultivating the science and art of obstetrics, so that we may, by new provings of drugs, discover specifics that will materially alleviate the many painful reflex symptoms that occasion so much distress and danger to pregnant women. If this is done in a painstaking manner, we believe that the accidents and fatality attending confinements will be materially lessened.

We may then hope to exhibit, in private practice, as good results as have been attained in well-conducted lying-in hospitals.

As accoucheurs, in practicing our holy vocation, let us ever remember,

"A mother is a mother still,  
The holiest thing alive."

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IMPOTENCE CURED BY SUSPENSION.—Relying upon the results of suspension in tabes, as recorded by numerous authorities, Dr. S. Istomanoff tried it in ten cases of impotence. Most of the cases also complained of spermatorrhœa and emissions. All ten cases were cured. The number of suspensions varied from twenty-four to fifty-one, in different cases. The emissions ceased after nine, ten, twelve and twenty-four suspensions respectively.—*St. Petersburg Med. Wochenschr.*, 12, 1890.



## OTACOUSTIC TREATMENT AS AN ADJUNCT TO FORMER METHODS OF TREATING DEAFNESS.

BY W. R. KING, M.D., OTOLOGIST AND OPHTHALMOLOGIST TO NATIONAL  
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SOME two years since, my attention was drawn to an account of a meeting of the College of Physicians, Philadelphia, at which this subject was presented to that body by the discoverer, Mr. J. A. Maloney, of this city, and afterwards my attention was again drawn to it by a publication of its presentation and discussion before the American Otological Society at New London, Connecticut. As the discoverer resided in this city, I determined to have a personal interview with him, and, at my request, he called and explained his method and means. It having been presented with clearness and a knowledge of physiological acoustics satisfactory to me, I determined to give it a fair and impartial trial, and with that end in view I selected cases of a typical nature as they presented themselves, believing that the best mode of procedure for a crucial test. The results of which, up to this time, I am pleased to report as follows:

CASE 1.—Mrs. Nettie W. C., aged thirty-three years. Scarlatina at eight years.

Right ear: Very little hearing power, and then only without distinctness through old form of hearing-tube, but the constant use of tube (entering the external auditory canal) had set up irritation and consequent pain upon use.

Left ear: No hearing power. Almost complete destruction of membrana vibrans, a portion of membrana flaccida remaining. There was naso-pharyngeal catarrh and hypertrophied tonsils. After treatment for a while, I determined, as before stated, to see what "otacoustic treatment" would do for this case, as there was no sign of awakening hearing power. After an examination of patient by Mr. Maloney, he advised absolute rest or disuse for right ear during treatment, and "otacoustic treatment" for left ear alone for time being (this ear not having been used for twenty-five years.) He also called my attention to defective articulation of patient and requested me to note effect of treatment of that as well.

*Treatment* in this case consisted largely of the use of the routine local or mechanical measures, viz., inflation of Eustachian tube and

middle ear by means of the Politzer bag and the Eustachian catheter; Faradism, positive pole at orifice of Eustachian tube and negative pole in the external meatus and on mastoid process; and internal homœopathic remedies, such as kali mur., dulc., strychninum, pilocarpine mur., etc., as they seemed to be indicated, together with "otacoustic treatment" twice daily.

After one month's use, the patient wrote, under date of February 21, 1888:

"It is now one month since I began 'otacoustic treatment,' in addition to regular treatment, and I find that, when I read to myself, there is a sharpness to the voice that I never heard before—many words have a drawl, and, *horror of horrors, a wretched lisp*—of all detestables that is the worst."

This was her first knowledge of the defective articulation. Under date of June 23, 1888, she wrote:

"In regard to otophone prescribed for me, after using it since January 21st last, I cannot find words to express the pleasure and happiness its use gives to me, as my left ear has been of no use to me for twenty-five years, and it is upon that ear I use it. You will remember at first use you were obliged to speak in a very loud tone of voice to make me understand a sentence or conversation; now I can hear a whisper through it. You remember also that I could not hear myself talk through it; now I can hear myself read, and note every peculiarity of speech that long deafness has brought upon me. The noise in my head has changed from the thunder roar of Niagara to a sound like distant music, and that occasionally changes to a sound like the sighing of the wind through trees. I would not part with the otophone for any money, and believe it to be the only instrument a deaf person should use. Trumpets and speaking-tubes used by me heretofore—because of entering the ear—had a very detrimental effect upon me, and I believe them to be very injurious. If all deaf persons could know of 'otacoustic treatment,' there would be less despondency and nervousness. Respectfully,  
"MRS. N. C."

At this time, condition of both ears had changed; patient could now hear sermons without any aid to hearing, and the articulation had improved to a marked extent.

CASE 2. Ralph G., aged 12. Diphtheria at 6. This case was even more remarkable than the foregoing one. Before being brought to me, the boy had been taken by his mother to many of the leading otologists here and abroad.

Right ear: No hearing for loud voice, close to meatus. Destruc-

tion of M. T., save a portion of membrana flaccida, or "Shrapnell's membrane."

Left ear: Otitis purulenta, exacerbations frequent from exposure, pain relieved by discharge. M. T. perforated and sclerotic inflammation with suppuration frequently recurring. Slight naso-pharyngeal catarrh. Excessive hypertrophy of tonsils (almost touching each other.) The diagnosis made abroad was paralysis of auditory nerve; this was verified (?) by one or two specialists in this country. The boy was an expert lip-reader; he had the "deaf face" well developed. By appointment I had Mr. M. meet the boy at my office for examination and prognosis. The boy heard readily after a moment or two through best ear, and within three or four minutes through worst ear. The mother could scarcely realize his hearing upon the right side. Mr. M. made a favorable prognosis for development to serve practical purposes through life; and even upon right side without M. T. or ossicles. I must confess that I was somewhat surprised for the moment at this prognosis, for in my long experience here, and even while in Vienna, I had never seen or heard any hope held out for such a case; but I concluded to be patient and watch for results.

*Treatment.*—Attention was first given to the condition of frequent suppurative inflammatory attacks in the left ear—frequent inflations by Politzer's method—thorough cleansing and antiseptic treatment locally applied, and calc. carb. 30 was given for the dyscrasia with hepar sulph. 3x to be used when an acute attack was pending, and during the inflammation and suppuration. Local treatment of a detergent and astringent character helped materially the condition of naso-pharyngeal catarrh and insufflations of soda bicarb. on the tonsils was soon followed by a complete reduction of the hypertrophy. Otacoustic treatment was begun, and the hearing power was brought up to a condition within sixty days as follows: The boy could hear ordinary conversation at ten or twelve feet with ease, and when I last saw him, many months since, the improvement remained fixed. The "deaf face" consequent upon mental strain from lip-reading had disappeared; he was ruddy and robust, and I think it would puzzle an expert to discover that the boy had ever been profoundly deaf.

CASE 3. Mrs. W. W. H., age about 46. Deaf for fifteen years.

June 1, 1889. Right ear: History of deafness for fifteen years. W. on contact = 0. Left ear: W. aerial =  $\frac{8}{16}$ . Fork test B. C. good. M. T. Sclerotic, opaque, retracted. Atrophic nasal catarrh.

Dryness nose, throat. "Tinnitus aurium" very persistent and varying. Patient was very skeptical of prognosis made by Mr. M. after examinations and tests, but her husband who was present and who witnessed tests, urged her to try the treatment, which she reluctantly did. After thirty days the following surprising results were shown: W. R. E. aerial =  $\frac{2}{80}$ ; W. L. E. aerial =  $\frac{2}{80}$ . Ordinary conversation heard readily in any part of room, *when patient is not looking at speaker*. "Tinnitus aurium" very much reduced. The improvement still holds in this patient up to this time. I may here add that this case presents remarkable features, as the patient is a neurotic, and then, as now, in the climacteric period.

*Treatment.*—Local; inflation on both sides, with Politzer bag and Eustachian catheter, at first twice and later once weekly. Faradism applied, as in Case No. 1 of this report. Cleansing and stimulating treatment directed to atrophic rhinitis. The constitutional treatment in this case has required the use of various remedies, owing to the many complications involved in so marked a neurotic. The remedies mainly directed to the conditions immediately in the deafness were kali mur., chinin., ars., dulc., lachesis, strychninum and pilocarpine mur.; the best results seemingly following the use of the latter remedy, together with otacoustic treatment.

CASE 4.—Miss Julia S., aged 65. October 10, 1889. Profoundly deaf, both sides. R. E. W. A. = 0; C. = 0; L. E. W. A. = 0; C. = 0; F. T. (fork test), A. = 0; B. C. fair. Expert lip-reader. Atrophic "Otitis Media Catarrhalis." M. T. retracted, opaque. Patient was seen at my office by Mr. M. Examination made and treatment adopted. After sixty days the following result: R. E. W. = C.; L. E. W. = A.  $\frac{2}{80}$ . Could hear unaided voice for moderate tones eight feet. This patient then returned to her home in the West.

*Treatment.*—Local; consisted in the employment of about the same methods as were used in Case No. 3, though seemingly in themselves of very little benefit. The principal remedies used were kali mur., alumina, nux vomica, and pilocarpine, as they seemed to be best adapted to the existing condition. I neglected to state that the Faradic current first, and later the galvanic, was used in both sides with some manifest benefit following each application; however, this was again much more marked after beginning the otacoustic treatment.

CASE 5.—Mrs. L. L. S., aged 75. Senile deafness and rapidly increasing. After examination by Mr. M., prognosis was moderate

improvement and retention of same. Treatment adopted; moderate improvement followed. I am pleased to state that although I have only seen the patient once during the year the improvement in the beginning has been maintained. This is a very good result, considering age of patient and absence from the city and from watchfulness.

*Treatment.*—Local. Inflation both sides, and Faradic current continued only for a short time, as she soon left this city to return to her new England home, taking with her an otophone with full instructions for the continuous daily application of otacoustic treatment.

CASE 6.—Mrs. A. C. W., aged 29. August 29, 1889. Atrophic middle ear and tubal catarrh. M. T. dry, opaque, retracted. R. E. (very sensitive) W. = C.; aerial = 0; L. E. W. = C.; aerial = 0. Otacoustic treatment adopted. At this time (April 19th, 1890), conditions are: R. E. W. aerial =  $\frac{5}{8}$ ; L. E. W. aerial =  $\frac{3}{8}$ . Ordinary conversation readily heard at ten feet with back to speaker.

*Treatment.*—Local. Inflation both sides. Faradic, and later, galvanic current, both sides. Cleansing and stimulating applications to nose and pharynx. Remedies, given at different times, included china, chenopodium, kali mur., dulc., and strychninum. The last two of which she is now taking together with otacoustic treatment, and continuous improvement is manifest.

CASE 7.—Mr. J. M., aged 75. November 21, 1889. Deafness twenty-five years. R. E. W. = C.; L. E. W. = 0; fork test, aerial = 0; B. C. fair. Hypertrophic nasal catarrh. Mouth-breather. Otacoustic treatment adopted. On December 17th this person (being an out-of-town patient) wrote:

“My left ear, which was the worst, has developed hearing power considerably.”

*Treatment.*—Local. Inflation both sides, with local cleansing and astringent applications for relief of hypertrophic rhinitis. Remedies used up to time of his departure from the city (within thirty days after first seeing) were kali bich. 6x and pilocarpin mur.  $\frac{1}{100}$ . This, together with otacoustic treatment, which is still being used and with benefit.

CASE 8.—Miss Annie B. DeL., aged 24. January 16, 1890. Post-scarlatinal deafness since early childhood. R. E., W. = 0; L. E., W. =  $\frac{2}{8}$ .

Fork test: R. E., aerial = 0; L. E., aerial = 6 in. B. C., good.

Chronic muco-purulent discharge from left ear. M. T. *right*, opaque, retracted and full of cicatrices. M. T. *left*, perforation in

inferior posterior quadrant and tissue bathed in muco-purulent secretion. *Expert lip reader.* After examination by Mr. M., "otacoustic treatment" was adopted and directed to development of hearing in worst ear, with disuse, and absolute rest (by closing meatus with wool) for left ear during medication. At the end of thirty days "otacoustic treatment" was used on both sides, the purulent discharge from left ear having subsided. At this date (May 3, 1890) conditions are: W., aerial, R. E. =  $\frac{8}{10}$ ; W., aerial, L. E., =  $\frac{3}{5}$ .

Ordinary conversational tone of voice can now be heard, R. E. = 5 feet; L. E. = 10 feet; without listener seeing speaker.

*Treatment* was first directed mainly to the suppurative condition existing in the left ear and consisted of thorough cleansing by the use of peroxide of hydrogen (15 vol.) locally, followed by careful drying of canal and insufflation of boric acid; at the end of three weeks the ear was dry and clean and still continues so. Inflation both sides; suitable local treatment was directed to an existing nasopharyngeal catarrh. Faradic current has been used latterly with evidently some good effect, particularly as regards a severe hemi-crania which has annoyed her frequently and been very severe. The remedies used have consisted of silicia, calc. carb., kali mur., dulc and pilocarp. mur.  $\frac{1}{100}$ . The last named being of most service and is at present being exhibited, together with otacoustic treatment, producing continuous, steady, though slow, increase of hearing power and improvement of general health. These results are certainly satisfactory, particularly when we take into consideration the length of time the conditions predisposing to deafness have existed, and from my experience I do not hesitate to say that "otacoustic treatment" for its effect upon the middle ear during treatment, either local or systemic, is invaluable, particularly where adhesions of ossicula are produced by catarrh of middle ear, or as sequelæ of exanthematous fevers in childhood, which later on led in some cases to partial an-chylosis. It has been particularly useful in developing hearing in children who were supposed to be devoid of any power of audition.

The above cases were selected mainly because they are strictly typical and many of them represent profound degrees of deafness, in the most common class of cases; those wherein the conducting apparatus of the ear is at fault; and because in the majority of these cases careful local and medicinal treatment had been given for a longer or shorter period with little or no result; benefit of a marked and permanent nature only following the addition of otacoustic treatment to that already in use.

## CONCERNING REPERTORIES.

BY E. M. HALE, M.D., CHICAGO, ILL.

(Read before the Indiana Institute of Homœopathy, May 15, 1890.)

I HAVE selected this subject, because the conclusions which will be embodied in this paper, have been rooted in my mind for several years. I doubt not that many of your society have thought as deeply on this subject, and will approve of the conclusions I have arrived at. A repertory, as the homœopathic school understands it, is an index of the symptoms supposed to have been caused on healthy human bodies by the administration of drugs either by accident or design. If caused by the latter method, the symptoms are called "provings." Now, the primary, fundamental question to solve, before we can consider the value of our repertories, is: Are the so-called provings, or symptoms from cases of poisoning, *trustworthy*? If they are, then our repertories are valuable. If only a few or a part of the symptoms are genuine, then the repertories are of doubtful value.

Let us examine into the sources of the symptoms which are recorded in our vast materia medica. Those which are taken from cases of poisoning, are liable to be untrustworthy for several reasons.

(1) Many of them are due to the chemical action of the drug on the secretions of the body, or upon the surfaces with which they come in contact; (2) Many are due to caustic effects, or local destruction of tissues; (3) Many are due to fright or anxiety of the sufferer who fears the results of the drug-effects; (4) The symptoms of the antidotes and palliatives used. Evidently, all symptoms from the above causes, are valueless for all therapeutic purposes, if the drug is prescribed according to the law of *similars*.

There is only left us those symptoms which are uniformly experienced when the drug is taken. If, in a dozen or more cases of poisoning by arsenic, certain symptoms are invariably present in each case, or nearly all, then these symptoms are of undoubted value. So, in our provings, only the repeated, verified and notable symptoms are of real value.

Notwithstanding this fact, innumerable hosts of trivial and imaginary symptoms, not to mention many natural sensations are mentioned in repertories as indications for the use of medicines in disease. It may seem a startling statement, that a large majority

of the symptoms in our materia medica are imaginary, or are natural sensations. To illustrate, I will give a few illustrations. I will not weary you by citations, because they are too many, but will state that thousands of the symptoms introduced into our pathogeneses of drugs were recorded by men who took only *one dose* of the 6th, 15th, or 30th, sometimes the 1,000,000th dilution of a drug, and then recorded *all* the symptoms, even the minutest, for a period of thirty, sixty and ninety days, without repeating the dose. In the meantime, the so-called provers were subjected to all the influences from indigestion, colds, catarrh; all the influences from bad weather and improper food, and a hundred other causes, which go to make up uncomfortable sensations. But all these symptoms were gravely recorded as caused by the one infinitesimal dose of the drug! If you will examine, with an unprejudiced mind, such provings as sulphur, graphites, lycopodium, calcarea, etc., you will be astounded by the hundreds of sensations, such as you all feel every day of your life, but do not think them of any importance. But the greatest, most absurd and lamentable mistakes made by the early provers, even Hahnemann himself, was to record, as pathogenetic symptoms, thousands of aches, pains and uncomfortable sensations, which were supposed to be removed from the sick, after the remedy was given. How did they know that the medicine removed the symptom? Because they disappeared, was no proof. In a case of continued fever, or illness, when left to a natural course, the symptoms change every day or two. They are fleeting and transitory. If a few persistent pains were removed, and this was verified in several cases, then we might add them to a pathogenesis. Worse than this. Many physicians recorded as pathogenetic symptoms those which arose or appeared in sickness, *after* a dose of a drug was administered, ignoring the fact that new symptoms appear every day during an illness when no medicine is given. The introduction of such symptoms into our materia medica was unwarrantable, and will always be a disgrace to us. It is high time that a complete purification and revision of our materia medica was accomplished.

The work in progress by Hughes of England and Dake of America is good, so far as it goes, but they have not been bold enough in expunging and lopping off the false and spurious symptoms which abound in many provings. Until this is done we *cannot* have a trustworthy repertory.

That I am not alone in my views of this subject is shown by the following extracts from a lecture by one of our most thoughtful and



logical men, Dr. Conrad Wesselhœft, of Boston. Alluding to repertories, he says :

"If repertory-making has yielded a golden harvest to industrious writers, they are welcome ; but, to their honor be it said, that they wrote more for the love of writing than for material good. The large and growing symptom lists, detailing the effects of drugs, appealed to their imagination and gave it play. There was a fascination in arranging and rearranging 'symptoms,' and none worked in this field more industriously than my old friend Hering, with whom repertory-making became an infatuation which was caught by many others. But in all this work it was remarkable that none sought for the real sources of their material to see how it was obtained, and whether it was reliable or not ; the hugeness of the mass did not deter them ; the greater it was, so much the greater the fascination of building repertories. But the medical student, where was he ? When confronted, thirty years ago, with Hempel's translation of the pure *materia medica*, or Jahr's *Manual*, he was reluctant to take hold of it ; and to-day, in the presence of Allen's ten volumes, he simply shrinks away in despair. To begin with, this accumulation came about by the position taken by the founder of our system, that everything which a prover experiences after taking a dose of a drug, be it a pellet of the 30th or a drop of a tincture, must come from that dose, and from nothing else." (*Org.*, § 138.)

"The error was multiplied by the further assumption—natural enough at the time—that no matter how much provers might differ, this disparity was no evidence against the correctness of their method. They must keep on recording symptoms as long as any appear, and until they begin to observe upon themselves mostly symptoms like those already experienced by others." (*Org.*, § 135.)

I have now been an adherent of our school for nearly forty years, and have done some work in it. I have assisted in the making of some repertories, and have carefully studied all of them, partly to verify them and partly for their aid in the selection of the indicated remedy. My opinion as to their relative value may therefore be of some use to the younger members of the profession. The first repertory that came into my hands was Hull's *Jahr*. This was a translation of Jahr's *Repertory*, with a few additions by Dr. Gerald Hull, of New York. Probably because I used it so much in the first years of my practice, I still consider it the best repertory in our school as far as it goes. Dr. Snelling, about twenty years ago, edited a new edition, with amendations, including the new remedies up to that date. But both editions necessarily contained many misleading and unreliable indications, because the editors and compilers felt obliged to include *all* symptoms.

The *British Cypher Repertory* was a very ambitious affair, and a stupendous undertaking. Probably few of you ever saw the two or three parts published. But you need not regret it. It was like studying the Chinese language, and the benefits derived would not have paid you for the labor and trouble. The next repertory, written on a different plan, was Hempel's. It made the third volume of this great *materia medica*, or *Symptomen Codex*. In this, under appropriate headings, each symptom was given in full, generally with its closely-associated symptoms. In many respects this was an admirable repertory, for it did not require you to study the pathogenesis of each drug. It has been and still is a great aid to me in the study of difficult cases. A curious repertory, relating to *Uterine and Vaginal Discharges*, was once written by Dr. Eggert, then of Indianapolis, now of Santa Fe. It must have cost much labor, but I doubt if many ever gained signal benefit therefrom. Then came many special repertories on *Diseases of Women*, *Intermittent Fevers*, on *The Eyes*, on *Whooping-Cough*, *Diarrhœa and Dysentery*, and many other subjects. Finally, appeared T. F. Allen's great *Symptom Register*, which, vast and voluminous as it is, is the most useless and worthless of them all. I do not deny that it may be of some value, but I must maintain that, after all, it was a waste of labor and of time which might have been used to better advantage. Hering's repertories were wonderful examples of the painstaking, analytical type of the German mind, given to extreme hair-splitting and endless repetition like the ever-varying pictures of a kaleidoscope.

His repertories are only equalled by Farrington and his imitator, Kent, in their endless and prolix "comparisons," which, while they glitter with symptoms, dazzle the mind and befog the judgment and understanding.

Speaking of comparisons, I cannot refrain from alluding to Gross's so-called *Comparative Materia Medica*, which was in reality only a kind of repertory. Such was its innate worthlessness that it fell almost still-born from the press. Several years after, one Dr. Jussen attempted a similar work, which was published, but, much to the grief of its author, it met with the same fate.

One of the most elaborate special repertories is that on the "Heart," which forms a part of the last edition of my *Diseases of the Heart*, 1890. It was written by Dr. Snader, of Philadelphia, and is a marvel of patient labor. But probably the most stupendous repertory ever planned is the *Concordance Repertory*, now being compiled by Dr. Gentry. When finished, it will make seven large octavo

volumes of over 700 pages each. I sincerely hope that the author may live to finish it, and I hope that some of our school may reap great benefit from a study of it, but I have serious misgivings as to its practical value.

Gentlemen, the repertory of the future will be a small book. It will refer only to characteristic, verified symptoms, and can be carried in the vest pocket. But the time is not yet, nor will it be written while those who listen to this paper are living. It will require a century to eliminate the worthless and spurious symptoms from our already vast *materia medica* and its future additions.

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### A FEW SUGGESTIVE CASES.

BY E. H. PRATT, M.D., CHICAGO, ILL.

THESE are two cases which especially attracted my attention to the marvellous action, upon the capillary circulation of the blood, exercised by the sympathetic nerve which should be placed upon record, and I hereby apologize to the profession for not writing them up before.

Some eight years ago the city of Chicago was visited with a devastating epidemic of diphtheria. Among the cases that were attacked were two young women, both of them married, each of whom had given birth to a child one month previous to their attack by diphtheria; both of whom were apparently healthy and in good general condition at the time of the attack, and yet one died and the other recovered.

It is the means whereby the recovery of the one was effected which so startled me at the time, and has clung to my memory ever since. Both cases were very malignant ones. In the case who died the heart's action seemed to be badly interfered with; the tissues about the neck became so oedematous as to make the neck protrude evenly with the chin; the woman seemed so completely asphyxiated as to become fairly purple, and her eyes protruded from the sockets. She stretched out her hands and pleaded pitifully for assistance, which I was unable to give her. She lived for two days. I perhaps visited her a dozen times within that time. I tried everything at my command for her relief in the way of local application—both internal

and external—hot and cold, everything, in fact, except tracheotomy ; and I was satisfied that her asphyxiated condition was due not so much to œdema of the glottis as to the weakness of the heart's action ; so decided that tracheotomy would afford her no relief and did not attempt it. I can never forget, while memory lasts, the terrible countenance, first pleading and appealing, tearful and, finally, as she saw her pleadings for me to relieve her of her difficulty of breathing unavailing, they became fairly malignant ; and I have never seen a wild beast glower as that woman glowered at me in the desperation of her death-throes. The case prostrated me badly ; and it has lingered as the shadow of a nightmare in my memory ever since.

The other case was exactly similar to this one in its incipency, both as to the age of the parties, their comparative strength, the length of time after birth, the ability of the family to afford me any assistance within their power, and in the malignancy of the attack, as well could be ; but there was this difference in my knowledge of the cases : This lady I had treated some years previously for a retroflexed uterus, and realizing that a uterus was much like a pendulum and after gestation was prone to resume the exact position which it sustained previously, and knowing also that in a sub-involuted state, when recent, the uterus is much like putty and can be moulded to one's will ; in other words, realizing that local treatments when needed were more effective after confinement than at any other time, I decided to do what I could to relieve this woman permanently of her retroflexion which I had attempted to correct before her gestation, but had failed ; so that just before her attack of diphtheria I had given her one local treatment and had noticed that the uterus was badly retroflexed ; and as was my custom at that time I passed a tampon medicated with *pinus canadensis*, in such manner as to most effectually relieve the displacement. This was on a Sunday, just a month after confinement. The next day she took a long drive, and also a cold, and upon her arriving home suffered slightly from sore throat. Supposing it to be nothing but a sore throat, the family did not send me word until the diphtheritic poison (which it turned out to be) had well infected her system for twenty-four hours ; and when I was summoned to the house I immediately detected the poisonous odor in the lower hall before I ascended to her room ; having suffered twice from diphtheritic attacks myself, and being very sensitive to this poison, I knew by the peculiar effect which it immediately produced upon my own throat that I was sur-

rounded by the poisonous atmosphere. As soon as I entered the sick-room I noticed that the air was stifling with the dreaded contagion. The other case of which I wrote had been dead but a week. In the creature before me I saw a repetition of the scene, and my heart sank within me, as I felt that I was perfectly powerless to relieve the woman. Her throat was swelling very rapidly, so rapidly that it was perceptibly increased during my visit, which was about fifteen minutes, perhaps. I left remedies for her and returned again in a few hours to find the patient very much worse, in fact cyanotic, and having such a difficulty with her respirations that she was wholly unable to lie down. I don't know where our suggestions come from; I do not know what kind angel sometimes opens the windows of our souls and whispers us suggestions that savor of inspiration; I cannot tell, will not try to explain, why I thought, with that woman choking for breath, with her throat covered with diphtheritic patches and exhaling volumes of poisonous breath into the air about her, why I stopped to think of her uterine condition. But I at once resolved to investigate it. She told me that it was impossible, as she could not lie down. I was so determined in my course of action that I compelled her to lie down, absolutely held her; as I saw that she was in a frantic condition, almost irresponsible for what she was doing, and I felt that I had to take desperate measures for her relief, and I was determined to know the condition of that uterus. I found that it was again badly displaced, perhaps due to her ride and subsequent climbing of stairs—perhaps because the tampon which was placed did not properly retain it in position. But while she was lying with my index finger just below Douglas's cul-de-sac, I crowded as far upward as possible the fundus of the uterus and then, with my thumb of the same hand placed in front of the cervix at its junction with the body, crowded the whole organ upwards and backwards to the extent of my ability, the woman struggling in the meantime for breath. I no sooner succeeded in placing the uterus in position than the woman began to experience so much relief in her respiration that she was perfectly willing to remain in a recumbent position. Wishing a little time to think what it was best to do—astonished at the quick action upon the respiration of replacing the uterus—I retained her in this position, holding the organ in place for about fifteen minutes, and, to my utter amazement, before my very eyes the swelling of the neck and the cyanotic condition, which before had been increasing by the half-hour, began to diminish much more rapidly than they had previously increased.

It did not take me long to visit my office, secure a retroflexion pessary and introduce it in such manner as to hold the uterus in its proper position.

The remarkable part of the case to me was this marvellously rapid improvement from the time I replaced the uterus with my fingers. I believe now, that had I known enough in the first case to examine the woman's uterine condition, I could have saved my first case, because the cases were so similar in every respect; but this taught me a lesson upon the action of the sympathetic nerve force upon capillary congestion, and was one of the incidents of my life which have compelled me to think deeply and long upon a line of thought which ultimated in the development of the orificial philosophy.

At this time I had little dreamed of the orificial philosophy, knew very little of reflexes, and was fairly stunned by the magic effect of replacing a uterus upon the case. I have since had a few similar experiences, where the replacement of the uterus has instantaneously relieved acute congestions. The same is frequently true of rectal conditions; and in this connection I should like to relate one case which occurred in my experience about three years ago. A neighboring surgeon had injected some hæmorrhoidal tumors in a plethoric lady of fair health. For two or three days subsequently no serious symptoms supervened. On the third day, however, in attempting an evacuation of the bowels, the tumors became prolapsed, and she was unable to replace them. Without any premonition whatever she became suddenly strangulated, being wholly unable to inspire. Her face became purple, her eyes bulging. The family, of course, became intensely alarmed. While I was at my dinner a summons came to visit her, saying she was dying. Knowing nothing whatever of the case, and having engagements ahead, I dispatched my assistant to the scene of distress. Immediately upon entering the room he observed her cyanotic condition, which at this time had become quite extreme; in fact, the patient was by this time covered with a cold, clammy perspiration, her eyes were fixed as in death, and the case looked moribund. Knowing nothing whatever of the nature of the case, my assistant had to stop to inquire as to what had been done before offering any relief. As soon as the facts were communicated to him he immediately replaced the hæmorrhoids, with the effect of instantly restoring the woman to life. In view of this fact I can but be surprised at the hazardous advice given by some of the so-called standard authorities on rectal troubles, that in order to bring hæmorrhoids into view, the patient should strain them down as forcibly as possible, and,

after they are well prolapsed, be placed under an anæsthetic for operation. It seems incredible to me that a surgeon of ordinary intelligence could handle a rectum for any length of time without observing the remarkable effect upon the respiration produced by strangulation of the tissues or dilatation of the sphincters, or any method which disturbs the normal position of the parts. It was not long ago, at one of the largest clinics in Philadelphia, that an eminent surgeon operated before his class upon a clinical case for fistula in ano. The anæsthetic employed was ether, and the house physician of the college administered it. The operation was successfully performed, the patient awoke safely from the anæsthetic and recovered. One year from that time the same patient presented himself at the same clinic for the same surgeon to operate upon him for hæmorrhoids. The same house physician administered the same anæsthetic (sulphuric ether), and the patient seemed to take it as kindly as at the time of the previous operation. The surgeon proceeded to operate, and, after bringing the parts into view, ligated a pile. He had no sooner tightened his ligature than the man sustained an immediate suspension of respiration. Thinking, of course, that the asphyxiated condition was due to the anæsthetic, restorative measures were immediately inaugurated. The patient was placed with the head downwards, artificial respiration was employed, hypodermic injections of stimulants were used, electricity was resorted to,—but all of no avail. After half-an-hour's hard work the case was pronounced hopelessly dead, and removed from the room; and yet so eminent a man as this great surgeon, who has lectured upon the subject of surgery to thousands of medical men (many of whom, in their time, have since become eminent), did not know enough to cut that string which bound the pile tumor; and I thought that if this man, with all his education and all his learned associations, has never learned the remarkable influence of nerves whose terminal fibres, distributed upon the last inch of the bowel, upon the respiration of a body,—what a lamentable lack of knowledge there must be upon this subject in the general profession.

As I mention this case in no spirit of censure, and as I entertain the most profound respect, both as a surgeon and as a gentleman, for the operator in question, it can do no harm to remove all spirit of mystery from the statement by saying that the operator in question was Prof. Agnew; and as I read his honest, straightforward report of the unfortunate case, I marvelled at the minute accuracy of his description of the case as it appeared in his report to the profession,

how "he had no sooner ligated the pile than the man stopped breathing." The case deserves mention because it is recorded as a case of death from ether. It belongs on the list of deaths from ligation of hæmorrhoids.

Had Dr. Agnew simply cut the string which bound the hæmorrhoidal tumor, he would also have freed the man, in all human probability, from the grip of death, or, if the mere cutting of the string were not sufficient, dilatation of the sphincters would have assisted him marvellously in his handicapped efforts to save a life.

In this connection it will be *apropos* to mention another case which has but recently come under my notice:

A weak, wasted, married and childless lady, of forty years or thereabouts, suffered from pelvic abscess, which finally broke into the rectum, but refused to heal. An eminent surgeon attempted a laparotomy, but found such adhesions that he could do no more than simply evacuate the pus cavity and establish drainage through the vagina and the abdomen. No pus drain through the vagina was established, and the tube was soon removed. The abdominal wound remained a permanent opening, as did also the rectal opening. A secondary abscess appeared in the course of a few months in the left groin, which was aspirated several times, but without permanent benefit. A little later on she developed septic symptoms, irregular chills, profuse sweats, rapid pulse, nausea. Menstruation had been suppressed for a year. Simply as an experiment, by means of a rectal bivalve, the anal sphincters were moderately dilated simply to what the patient could easily endure without an anæsthetic. The effect upon the patient was almost miraculous. All sepsis immediately disappeared, the function of menstruation reappeared, and, under an improved appetite, and the general boom experienced, the abscess nearly dried up. For some months it looked as though the patient would recover. In the course of time, however, the discharge increased once more, and she has recently been operated upon for radical cure of the abscess, by the packing process, from the abdominal wounds; but the septic symptoms never returned, and the case remains as a marvellous illustration of the power of an improved capillary circulation, attained by rectal dilatation, over the predatory inroads of septic microbes. Truly, life is lord of death, and a re-establishment of nutritive processes is the grandest and greatest of antiseptics.



## THE CYCLOPÆDIA OF DRUG PATHOGENESY.

REPORT OF THE AMERICAN EDITOR, J. P. DAKE, M.D., NASHVILLE, TENN.

(Read before the American Institute of Homœopathy.)

IN making my annual report of progress, I am pleased to say that the *Cyclopædia of Drug Pathogenesis*, being published under the patronage and guidance of this organization, as well as the British Homœopathic Medical Society, is approaching completion. Three of the four volumes are now printed. The fourth, and last, is well under way. Three parts of this closing volume will be required for the provings of remedies yet to be displayed. The fourth part will embrace the index or repertory for the entire publication. And the index will also refer, and be a guide, to symptoms in the "Materia Medica Pura" and "Chronic Diseases" of Hahnemann.

It was expected that the index would call for a fifth volume, and that it would require many workers and many months for its completion after the issue of our fourth volume, embracing the drug narratives. And I am pleased not only to announce the completion of the whole work in the four volumes, but, likewise that the learned and indefatigable chief editor, Dr. Richard Hughes, will be able to compile the index. As would be expected by those acquainted with the scholarship and thoroughness of Dr. Hughes and his familiarity with the material he has gathered and sifted and written into shape, the index will sooner be formed, and will be the more reliable and practical on account of its authorship.

As this is likely to be the last of my annual reports as an individual editor, and hoping to have Dr. Hughes with us next year to present our final report on the whole work, I desire to say some things in vindication of the policy and methods governing this Institute and the British Society in the production of the *Cyclopædia*. And I am also moved to the expressions I offer by a wish to have the work duly appreciated by the whole profession, as well as by the scholarly few, and to have its volumes taken off the hands of the Treasurer of the Institute, who is receiving and paying for four hundred copies.

The object of the Institute in subscribing for the four hundred

copies has been to encourage the publication and to enable her members to obtain the work at actual cost, or fifty per cent. lower than the price usually put upon similar works in the hands of a private publisher.

As I have mentioned in former reports, it had been the custom, from Hahnemann down, to arrange drug provings, the symptoms of drug influence upon the human organism, in schematic form, the natural order being broken up and the dissevered symptoms arranged under headings more or less arbitrary. The plan of the *Cyclopædia* has been to go back and gather up, as far as possible, the narrative of each drug proving and of each case of poisoning, and present them as originally noted. This plan gives the testimony of the most credible witnesses as to the rise, progress, characteristics, concomitants and results of each drug disease as experienced by various persons. It opens the way for the student to arrive at the natural history of drug affections, the real nature and tendencies of each, and affords to the practitioner the only possible way to a rational comparison of a case of disease presented for treatment with the similar drug affection; or, in other words, by no other known means is it possible to reach the totality of symptoms observed on the *materia medica* side, that shall be similar to the picture presented for comparison in the sick-room.

And this manner of pathogenetic record, alone, affords opportunity for determining what symptoms are characteristic or peculiar to a drug—what may be regarded as its constant effects as distinguished from its casual.

I cannot imagine, at this late day and among the learned members of this body, it is necessary for me to advocate the grading of symptoms as to their comparative value, by the direct and positive methods, which places those at the top that have been experienced by the greatest number of provers, and those at the bottom that have been experienced by the smallest number. This is the method adopted in every department of science and in every cause where the true is to be distinguished from the false and the real from the imaginary.

Other things being equal, the greater the number of witnesses testifying to a fact the greater must be its reliability.

In our *Cyclopædia*, with the testimony of twenty provers in regard to the effects of a given remedy, it is possible for the student to trace agreements, and so grade the symptoms upon a basis of congruence. Again, I would remark that our drug provings, comprising the symptoms of the *materia medica pura*, bear a relation to repertories,

manuals and epitomes, such as the records of the Bible, to concordances, commentaries, catechisms and creeds in the Christian church.

Any spurious statements and teachings in the sacred text, embraced, whether through ignorance or fraud, appear and reappear in each succeeding version and every manual and concordance and confession of faith that is issued. What would be thought of the wisdom of laborious, devoted writers in the church who should spend months and years comparing and arranging paragraphs from the Bible, under one heading and another, without having ever critically considered the genuineness of the text from which they were quoting?

And what must we think of writers in our school who work year after year, arranging symptoms in one way and another, without any proper inquiry as to the reliability of the records from which they are drawing?

Because some previous writer has collated certain symptoms and sent them out as drug effects, such writers accept and perpetuate them with no proper assurance of their genuineness.

This style of authorship has gone so far, so much time and labor have been bestowed upon such works, and so much money has been invested in them by publishers, it is not easy to have the results of critical examinations and of more thorough methods of cultivating materia medica accepted and approved. Too many in the profession, busy it may be, are slow to realize the defectiveness of what they have accepted and depended upon in their practice. They have done somewhat better than their allopathic neighbors with the helps in hand, and are not disposed to spend their time and money looking for something still better.

The generations of younger men, better acquainted with the exactions of science and logic, coming into the profession will thank those who, at Deer Park, voted to sustain the preparation and issue of the *Cyclopædia of Drug Pathogenesis*.

So far as the healthy, human vital test, applied to remedies, practically begun by Hahnemann, has gone in the production of a materia medica for homœopathic use, the work now coming to its close will most faithfully set forth its best results.

With its index it will meet the wants of the student and prove most useful to the careful practitioner.

Nothing more reliable can be found or produced till our remedies are re-proved with greater care and thoroughness, and with the application of more exact diagnostic tests and more discriminating records.

FORTY-THIRD ANNUAL SESSION OF THE AMERICAN INSTITUTE  
OF HOMŒOPATHY, HELD AT WAUKESHA, WIS.,  
JUNE 16 TO 20, 1890.

THE Forty-third Annual Session of the American Institute of Homœopathy was convened at Waukesha, Wis., on the evening of June 16, 1890. The Secretary of the Institute, Dr. Pemberton Dudley, of Philadelphia, called the meeting to order, after which Dr. E. M. Kellogg, of New York, obtained the floor and announced that owing to the serious illness of Dr. A. I. Sawyer, the President, and the absence of the Vice-President, Dr. Higbee, in Europe, the Executive Committee had decided to nominate Dr. J. D. Buck, of Cincinnati, to preside at this session. Dr. T. Y. Kinne, of Paterson, N. J., at once seconded the nomination of Dr. Buck, whereupon that gentleman was unanimously elected. Dr. J. P. Dake, the senior ex-President of the Institute was requested to escort President Buck to the chair.

On taking the chair, Dr. Buck referred in feeling terms to the sad incident that led to the necessity of selecting a president to fill the unexpired term of Dr. Sawyer. He thanked the Institute in appropriate language for the honor conferred upon him. Dr. Buck was enthusiastically received.

Dr. Willis Danforth then introduced the Rev. C. S. Nickerson, who delivered the opening prayer, after which he welcomed the Institute to Waukesha on behalf of the physicians of Wisconsin. Dr. Talbot, of Boston, replied.

President Buck then proceeded to deliver the annual address. This address, though prepared on very short notice, gave evidence of the most profound thought and study. The subjects presented therein were quite numerous, and the questions so concisely stated that an abstract would fail to do it justice, or give even an adequate idea of it.

Dr. J. P. Dake then moved the appointment of the following committee on President's address: Drs. J. H. McClelland, of Pittsburgh, Pa., George A. Hall, of Chicago, Ill., and W. H. Holcombe, of New Orleans, La.

The Necrologist, Dr. Henry D. Paine, of New York, then presented his report. The following members were reported as having died since the last session of the Institute: Edward Bayard, of New York, Horatio Robinson, of Auburn, N. Y., S. R. Dubs, of Doyles-

town, Pa. (these three were among the founders of the Institute), D. R. Gardiner, of Woodbury N. J., Joseph L. Martin, of Baltimore, Md., Martin Freleigh, of New York City, W. L. R. Perrine, of Brooklyn, N. Y., and L. B. Hawley, of Phoenixville, Pa. (all the above named were seniors), Gustavus F. Mathez, of New Bedford, Mass., John Malin, of Philadelphia, H. Noah Martin, of Philadelphia, W. B. Trites, of Philadelphia, R. F. Baker, M. M. Eaton, Randolph Titsworth, B. C. Shenstone, Charles L. Cleveland, W. J. Murrell, Theo. S. Keith, and Horace P. Hemenway.

Dr. T. Y. Kinne, of Paterson, N. J., then presented a report proposing that the Institute hereafter elect two vice-presidents, to be known as the first and second vice-presidents, according to the number of votes received by each. Also that the Institute begin its annual session on Monday afternoon instead of Monday evening as is at present the custom. By making this change much routine business could be gotten out of the way, and the evening devoted to the presentation of the President's address and the memorial service to deceased members. He expressed his feelings against the present custom of holding the memorial service at a time in the session when but a dozen or more members were present. Also that the bureau chairmen be requested hereafter to confine their bureau addresses to the subjects prescribed by the rules of the Institute. The abolition of the Bureau of Anatomy, Physiology, and Pathology was recommended, as at the majority of the meetings that bureau did but little work, and most of the papers presented by it could as well be presented to the Institute through one of the other bureaus.

The various items in this report were then referred to a subsequent session of the Institute for action.

Dr. E. M. Kellogg then presented his report as Treasurer. The balance on hand at the last report was \$606.46, and the total receipts from members \$4602.00, this being the largest amount ever received in any one year. The total expenses were \$3818.78, of which \$1631.86 was expended for the printing of the *Transactions* of the preceding year. The balance on hand was \$1454.68. The *Encyclopædia* account showed a great deficit, which would necessarily greatly reduce the balance of cash now on hand. Dr. Kellogg's report was referred to the Auditing Committee consisting of Drs. Kinne, Grosvenor, and Terry.

The reports of the Executive Committee and the Committee on Publication were then received and accepted. Dr. T. Franklin Smith, of New York, reported as Chairman of the Bureau of Organi-

zation, Registration and Statistics. Referring to the resolution passed one year ago, in relation to the listing of journals by the Institute, he said that the resolution in question had been submitted to all the journals, one of which declined to subscribe to the conditions of listing, and had, therefore, been dropped. Others, while subscribing to the resolution, qualified their acceptance by stating that they believed that the homœopathic law was the only law for the selection of drugs in the treatment of the sick. Favorable reports were received from the various institutions and societies under homœopathic control, after which the Institute adjourned until the following morning.

## SECOND DAY.

MORNING SESSION.—The Board of Censors reported favorably on the following applications for membership: Hiram E. Cross, of Baraboo, Wis.; W. P. Roberts, of Evansville, Wis.; C. L. Crandall, Burlington, Wis.; A. G. Leland, Whitewater, Wis.; L. D. Clark, Stoughton, Wis.; Q. O. Sutherland, Janesville, Wis.; W. S. Morrison, St. John, New Brunswick; A. W. Burnside, Chicago, Ill.; E. P. Colby, Wakefield, Mass.; J. F. Rothfeld, Concord, N. H.; J. P. Cobb, Chicago, Ill.; Gertrude Gooding, Providence, R. I.; Jos. Rodes, San Diego, Cal.; O. G. Tremaine, Ida Grove, Iowa; B. A. Sawtelle, Enfield, Mass.; A. J. Richardson, New York, E. M. Kanouse, Warsaw, Wis.; D. M. Brown, Waupaca, Wis.; B. A. Cole, West Lima, Wis.; R. C. Newell, Austin, Ill.; J. J. Thompson, Chicago, Ill.; W. T. Talbot, Boston, Mass.; P. W. Wright, New York; J. A. Gann, Wooster, Ohio; F. G. Barns, Lyssander, N. Y.; Mary W. Noxon, New York; A. B. Sanders, Boston; R. S. Perry, Indianapolis, Ind.; J. C. Kirkpatrick, Los Angeles, Cal.; E. D. Perkins, Ashland, Wis.; C. H. Thomas, Cambridge, Mass.; C. S. Mack, Ann Arbor, Mich.; George B. Best, Englewood, N. J.; E. Gillard, Sandusky, Ohio; Pearl Starr, Bellevue, Pa.; R. S. Marshall, Pittsburgh, Pa.; I. L. Green, Chicago; Thomas Love, Slayton, Minn.; C. G. Fellows, Chicago; W. P. MacCracken, Chicago; A. L. Monroe, Louisville, Ky.; E. G. Capron, Utica, N. Y.; W. A. Shappee, Xenia, Ohio; W. W. Gould, Rochelle, Ill.; T. L. Shearer, Baltimore, Md.; E. H. Parker, Eau Claire, Wis.; Lizzie A. Gutherz, St. Louis.

In the absence of its author, Dr. E. M. Hale read the address of the Chairman of the Bureau of Materia Medica, Dr. E. O. Kinne, of Syracuse, N. Y.

This address commented upon the necessity of the elimination of unreliable symptoms from our *Materia Medica*. All remedies should be studied with a view to classification. All remedies which manifested their influence in the same general direction should be numbered in one class, and stand for one classification. All symptoms common to all should appear at the head. Then under the individuals should be noted the symptoms or characteristics which make each one different from the other in its congeners. It is a recognized fact that such similarities do exist, and by grouping them at the head of the different classes, unnecessary repetition is avoided. Further, in making this classification, all symptoms should be ruled out that do not bear the indelible stamp of truth. There already exists in the *Materia Medica* an immense amount of matter, the origin of which is due wholly to personal peculiarities, concomitant circumstances, and, worst of all, imaginative vaporings. Relegate all these to innocuous desuetude and there still remains sufficient to engage the attention of the earnest student. With such a classification, those remedies which are bound by no common ties become of relatively as great importance, and will attract the attention they deserve for their single blessedness, if for no other reason. All new remedies as proven should be assigned to their proper class in the *Materia Medica*, enriching it by characteristic new symptoms they bring, without encumbering it with matter that has already been fully developed. Those remedies whose spheres of action seem to give them place in more than one class should so appear, and their comparative applications would thus be rendered more prominent.

Dr. H. C. Allen then read the address of the Chairman of the Bureau of Clinical Medicine, Dr. J. W. Dowling, of New York, who was detained at home on account of unusually important business.

The subject of the address was "The Importance of Etiology and Diagnosis in the Treatment of Disease." It treated the subject by the citation of a few interesting cases that illustrated the importance of this department of medicine. The author stated that given a healthy constitution at birth, unless disease-producing factors arise, the patients should remain healthy all their lives, and death should occur painlessly. In many cases of apparently obscure symptoms, as convulsions, asthma, etc., careful investigation will bring to light errors in diet, errors as regard methods of sleeping or ventilation or exercise. These being rectified, the trouble is readily cured. A gentleman, aged 47 years, gave a history of steadily increasing dyspnoea, beginning some months prior to his first visit. He could take but a few steps without resting, and was unable to sleep in the recumbent posture. He was in good flesh, and aside from this dyspnoea was in apparently perfect health. His family history was good, and his habits of life most excellent. He had suffered from a slight cold, with pleuritic pain. There had been no cough. Physi-

cal examination revealed the presence of a large accumulation of fluid in the right pleural cavity. The heart was dilated, and its action was decidedly irregular. There was reduplication of the heart sounds, which were very confusing in character. The urine was free from albumin. The fluid was withdrawn by paracentesis, and recovery, though slow, was permanent. The second case reported by Dr. Dowling was exceedingly interesting. It was that of a girl who presented to him a very peculiar appearance. Investigation showed that at the age of six years a surgeon had removed a tumor from the anterior portion of the neck, ever since which time there had been an arrest of development, although ten years had elapsed since that time. On examination the girl was found to be the subject of myxœdema. The surgeon, who by the way was an eminent one, had removed the thyroid gland. Here was a mistaken diagnosis which had been followed by disastrous results. The third case reported was that of a young lady who in childhood had had scarlatina and spinal meningitis. She had been perfectly well until about fourteen months prior to her first visit. After a severe mental strain she had hysterical convulsions, the attacks being preceded by hyperæsthesia of the auditory nerves, and were followed by depression of spirits. She feared loss of reason in consequence. She could not sit in a crowded room, and had great dyspnoea in a room artificially heated. She had never been subject to headaches, but had noticed great sensitiveness of the spinal column. The family history gave strong lithæmic manifestations on both sides. Physical examination showed nothing wrong except morbid sensitiveness over the mid-dorsal spinous processes, giving rise to sudden convulsions. She had a strong preference for animal food, and was a moderate user of wine at the table. There was a marked excess of urates in the urine. The whole trouble was ascribed to the liver as the organ at fault. *Lycopodium* was prescribed internally, and an almost exclusively farinaceous diet. The result of the treatment was simply marvellous. Lastly, Dr. Dowling described a case of dissecting aneurism of the abdominal aorta, in which physical examination during life failed to reveal the nature of the patient's sufferings, which consisted mainly of attacks of severe abdominal pain.

In closing the address, reference was made to the subject of neurasthenia. The writer thought that this diagnosis, in the great majority of cases, was but little more than a humbug, and that the remainder of such cases could be readily classed under the head of lithæmic conditions.

Dr. S. P. Hedges next read his address as Chairman of the Bureau of Gynæcology. The subject chosen by him was "The Importance of Diagnosis as an Adjunct to Treatment."

He first treated of the importance of diagnosis as an adjunct to treatment in gynæcological cases, after which he proceeded to review the progress made in that branch during the past year. The theory



that cellulitis is a distinct disease, he said, is no longer held. It is universally conceded that half a dozen different conditions were formerly embraced under that name. The history of tubal and ovarian affections is far better understood than one year ago. We now recognize the influence of gonorrhœa in causing inflammatory troubles in the tubes and ovaries. Early attention to this point may keep these cases out of the hands of the laparotomist.

Respecting *materia medica*, Dr. Hedges said that our attention should be directed to the more careful prescription of the remedy. He called especial attention to the tissue remedies.

At the close of Dr. Hedges's address, the Institute adjourned until afternoon.

**AFTERNOON SESSION.**—Sectional Meeting of the Bureau of *Materia Medica*. Dr. E. M. Hale presided in the absence of the Chairman, Dr. Kinne, of Syracuse. The first paper read was by Dr. H. C. Allen. Its title was "Provings of *Kali Phos.*"

These provings showed that the drug exerted a special action on the ear. The symptoms were not altogether reliable, owing to the fact that the provings were made during the "grippe season." In the mental sphere there was noted despondency in three provers; irritability in three; exhaustion after mental effort; pain in the temples, aggravated by mental effort; pains aggravated by motion of the jaw, and relieved by such gastric symptoms as belching and vomiting. There was also headache, beginning over the left eye, aggravated by heat and extending to the occiput. Pain in the left eye of throbbing character; quick, sharp pain in the left mastoid process (in five provers); profuse lachrymation in four persons, in two of which it was confined to the right eye; had to wipe the eyes to obtain clear vision; accumulation of thick mucus in the left inner canthus; aggravation in the open air. Nasal symptoms were found in all provers. The face had a number of itching pimples on it; there was also a pustular eruption on the face, but this was not very marked. The teeth felt sore when pressed together. They also felt as if longer than normal. The throat felt dry as a husk in the upper portion. The tonsils were swollen and congested, their color being dark. The soreness and swelling of the throat were worse on the right side; pain; uvula swollen, with pain aggravated on swallowing; pains running from the throat into the ear; gastric pains relieved by eating; early morning diarrhœa, stools coming suddenly and very profuse immediately after eating; stool of undigested food before and after breakfast; pains in the abdomen, worse after eating; flatulence; soreness about the umbilicus; cramping pains in the abdomen, relieved by bending double; dribbling of urine; unable to complete the act of micturition; frequent micturition; slow stream expelled with force; urine pale, containing a slimy white sediment;

sexual desire increased; emissions during sleep; erotic dreams. In women, sharp bearing-down pains with the menses; bloated feeling; restlessness; better lying down on abdomen.

In the discussion that followed, Dr. Monroe, of Louisville, said that he had relieved a case of typhoid fever, with hysteroid sobbing, with kali phos., after ignatia, coffea and hyoscyamus had failed.

DR. H. C. ALLEN said that he thought offensiveness of the discharges a very strong indication for kali phos. Dr. S. Smith reported several cases cured with kali phos. She thought the remedy especially valuable in functional heart troubles, with anxiety and restlessness.

DR. T. G. COMSTOCK said that he had used kali phos. in anæmia, melancholia and nervous debility. This closed the discussion on Dr. Allen's paper.

Dr. E. M. Hale then proceeded to read his paper on the "Cactaceæ."

He deplored the apathy of our school in the study and investigation of subjects pertaining to materia medica, the distinctive branch of the homœopathic school. He reminded us that the old-school physicians are awakening to this subject, so it behooves us to be on the alert in order to keep a safe distance in the van. The cactaceæ contain seventy-five genera and more than one thousand species, many of which are, however, useless in medicine. The medicinal powers of the order are to be found in the flowers and the bark.

*Cactus grandiflorus* irritates the intestinal canal, causing dysenteric symptoms. It has been used empirically for worms. The stalks and flowers, in order to be medicinal, must be mature. The principal symptoms of this drug are sensation as of a band about the heart, and this may be present in any portion of the body, and indicates congestion. It is a cerebral and spinal irritant. The patient exhibits mental anxiety and distress.

DR. H. C. ALLEN, in opening the discussion, said that the cacti needed proving. We have not too many symptoms belonging to them; in fact, we should have more. All the symptoms need not be memorized, but recorded so that they may be used for reference. He thought that it was our own fault that we were apathetic.

DR. T. G. COMSTOCK said that he had no faith in provings made with preparations from drugs above the third or fourth decimal dilutions. He thought that we should use appreciable doses in our investigations.

Dr. M. W. Van Denburgh, of Fort Edward, N. Y., then pre-

sented his paper. (This will appear in the August issue of the **HAHNEMANNIAN MONTHLY**.)

This paper was discussed by Drs. A. W. Woodward, of Chicago, and C. S. Mack, of Ann Arbor, Mich.

Dr. J. W. Heyward, of Liverpool, England, presented a paper entitled the "Repertory of the Future," which commended the *British Cypher Repertory* as the model. The paper was read by title, and referred for publication.

Dr. W. D. Gentry, of Roger's Park, Ill., next reported two cases cured by lachesis.

After a few remarks by Dr. H. C. Allen, the session adjourned.

**EVENING SESSION.**—The Censors reported favorably on the following applicants for membership: F. W. Morley, Huron, O.; N. H. Dale, Oshkosh, Wis.; A. P. Hedges, Chicago, Ill.; W. S. Dunn, Chicago, Ill.; E. D. Chapman, Defiance, O.; F. S. Whitman, Belvidere, Ill.; J. S. Daniels, Omro, Wis.; Charles L. Rumsey, Philadelphia, Pa.; H. P. Murray, Bronson, Mich.; C. R. Treat, Sharon, Wis.; J. W. Dennison, Washington, D. C.; H. J. Suttle, Uroguay, Wis.

The general session of the Institute then adjourned, and the sectional meeting of the Bureau of Clinical Medicine was held, Dr. H. C. Allen presiding in the absence of Dr. Dowling. The first paper presented was the one by Dr. H. P. Holmes, of Sycamore, Ill.

The case reported was that of a man who, for some time past, had been complaining of dyspeptic symptoms. There was marked loss of appetite, lack of power to retain or digest even the smallest portion of food. The attacks of vomiting became more and more frequent. There was evidence of partial pyloric obstruction. One very interesting symptom was the vomiting of blackberry seeds, which took place two weeks after the fruit was ingested. Physical examination failed to reveal the existence of a tumor. Gastric pain was present, but it was not of the radiating, shooting character found in cases of gastric cancer. The patient was in the highest degree anaemic. Though the author strongly suspected that the case was one of cancer with pyloric obstruction, he gave the diagnosis of atonic dyspepsia. Arsenicum was prescribed, and later conium. Improvement took place, but it was temporary. The patient then passed from Dr. Holmes's care. He then consulted various authorities, who gave him various diagnoses, as neurasthenia, hepatic sclerosis with atrophy. Ascites developed. Finally the patient died. The autopsy revealed the presence of a tumor of the lower two-thirds of the stomach, involving the pancreas. The abdominal aorta was surrounded by the tumor, but its calibre was not encroached upon.

The greatest benefit was obtained from the use of unfermented grape-juice and sweet whey, made by placing small pieces of rennet in sherry wine and then adding a few drops of this solution to new warm milk. The result was a very soft, sweet curd, superimposed upon a sweet whey, both of which were very nutritious.

DR. J. B. G. CUSTIS reported a case similar to that reported by Dr. Holmes, and called attention to the character of the pulse in these cases.

DR. C. E. LANING said that he too had had a case like that of Dr. Holmes. All kinds of diagnoses had been made, from nothing up. There were intense pains in the stomach at times, and vomiting was persistent. There were severe cramps in the abdomen and calves of the legs. Towards the last the patient developed a strong appetite and asked for a dish of corn beef and cabbage, which was given to him. He ate a tremendous meal of it, which seemed to agree with him perfectly. This diet was repeated two or three times, when it brought on great pain, and then was abandoned. Then something else equally indigestible was given, and this agreed with him for a short time likewise. The autopsy showed the presence of a gastric cancer.

DR. S. P. HEDGES recalled a case in which all who had examined it agreed as to the diagnosis. It was remarkable for the fact that the patient could eat the most indigestible food with as much readiness as the most delicate, while at times she could eat nothing without distress. The diagnosis given by all who had seen her was cancer of the stomach. A *post-mortem* examination showed the stomach to be perfectly free with the exception of a small portion of the posterior wall; but the pancreas was one solid cancerous mass.

DR. W. H. JENNY, of Kansas City, said that he had had a case of cancer of the pancreas in which the deposit of adipose was good.

DR. J. H. McCLELLAND said that many cases of cancer begin primarily in the pancreas. We rarely have real carcinoma of the liver that does not begin in the pancreas. It is interesting, in this connection, to state what Billroth does with these cases. He opens the abdomen, cuts off the bowel below the stomach and makes a new opening. He then closes the abdomen. The vomiting ceases at once. It is a procedure well worthy of consideration in severe cases.

DR. D. W. MACLACHLAN asked if the stools had been examined in Dr. Hedges's case.

DR. HEDGES replied that no examination other than ocular was made. Nothing unusual was noted.

DR. MACLACHLAN then said that nearly all of us have had cases of the kind under discussion. A strong point in the diagnosis of cancer was the age of the patients. He had also seen cases in which there was stricture of the pylorus, but no cancer. One symptom of these cases was that the patients would eat well for a long time, and then could take nothing. He accounted for such conditions on the theory that for a while stricture would exist, then vomiting would take place, relaxation would ensue and relief would follow.

DR. WILLIAM OWENS, of Cincinnati, made some remarks on the pathology of cancer and recommended acetic acid, internally and externally, as a valuable remedy.

DR. WM. WEBSTER, of Dayton, Ohio, said he had a number of cases of cancer of the stomach, but they all died. Where the disease commenced in the pancreas there was not that emaciation that one found when the disease was confined to the stomach alone. The stools were nearly always black and intermixed with white substances resembling chalk.

DR. T. G. COMSTOCK said that in three cases of malignant disease of the pancreas he had observed fatty stools. He asked if any one present had had any experience with rubinia. He had used this remedy in the attenuations, and had found that it afforded relief in cases of cancer of the stomach with commencing dilatation.

DR. J. H. McCLELLAND did not think it remarkable that all of Dr. Webster's cases died, as those of all others followed the same course. He had had a number of cases of so-called malignant disease of the stomach in which recovery ensued, but he had set them down as instances of mistaken diagnosis.

DR. WEBSTER said that he had relied upon arsenicum and rennet wine in these cases.

DR. MACLACHLAN said that in his cases of pancreatic cancer emaciation was extreme. Fat in the stools is regarded as an indication of disease of the pancreas. The appearance of the stools in these cases will vary very much. If there has been hæmorrhage into the stomach we will have black stools. The presence of fat in the stools is significant.

Dr. C. E. Laning then read a paper on the "Value of the Study of Reflexes." The following is an abstract:

Chronic diseases are developed in one of two ways, either as the result of a long lasting impression made upon certain nerve-centres by some sudden powerful influence, or by slight disturbing causes

long-continued. Cases classed as obscure are those in which the manifestations of disease are of such a nature as to make it difficult for the physician to ascertain the character or location of the lesion upon which they depend. Chronic cases are more frequently obscure than are acute ones, and, whether acute or chronic, cases become obscure or very largely so just in proportion as unique or many reflex symptoms are developed.

The importance of a knowledge of the various paths by which reflexes are conveyed can scarcely be over-estimated. Familiarity with the various sources from which reflexes may spring precludes the possibility of a belief in the teachings of those who claim that all, or that the great majority of reflexes arise from a single point, and that the sympathetic nervous system finds its origin in the solar plexus.

A careful analysis of reflexes has shown that there are what might be termed primary, secondary, tertiary, and so on, reflex paths, leading from each point capable of giving rise to reflexes. What I mean by this is, that a lesion being set up in a given organ or nerve-centre it will send out its reflexes most frequently in a certain direction along certain nerve trunks. This represents what I have termed the primary reflex path. Again, let the same organ be affected, and the reflex may extend in altogether a different direction, though doing so in a less number of instances than it would in the first case, the last path representing a secondary reflex route. By way of illustration, the author referred to diseases of the colon. Here the primary reflex path is to the head, producing headache and more or less melancholia. The secondary reflex path leads to the stomach, giving rise to dyspepsia. The tertiary reflex leads to the lower limbs, causing a feeling of dull aching, sometimes with paralytic weakness. Dr. Laning then proceed to describe several cases as illustrative of the above remarks. Case I. was that of a woman between thirty and forty years, who had always had good health until one year before consulting him. For a number of months she had been much troubled with her stomach. She had pain of a dull, aching character, and a most constant nausea. She was unable to eat with regularity, and emaciation was marked. There was no cachexia. There was slight tenderness over the stomach, but no sign of induration or tumor. Gastric lesion was excluded. Further examination showed a spot on the ascending colon a few inches above the ileo-cæcal valve, sensitive to deep pressure, which caused increase in the gastric distress. The nausea was also increased. After repeated inquiry, it was elicited that some weeks before, when holding her little girl, the child suddenly kicked her quite hard in the abdomen, causing some pain and a sense of faintness. Over the point where the traumatism occurred there developed quite a soreness and tenderness, which lasted a few days, then gradually disappeared, and had been almost forgotten. There was no evidence of any catarrhal condition of the colon, in short of any lesion, except a circumscribed induration as a result of traumatism. Conium 3x was prescribed accordingly. In a few

months the patient was relieved of every vestige of her trouble. This case, Dr. Laning stated, illustrates that in almost every case there are symptoms which have no therapeutic value. There are in in a given case symptoms which indicate the site of the lesion, some its nature, and still others which indicate the curative remedy. The second case reported by Dr. Laning was that of an obscure and obstinate case of facial neuralgia, which had resisted all treatment. It was accidentally learned that the patient suffered from ingrowing toenail, manipulation of which excited the neuralgic pains. After the irritation resulting from the nail had been removed by operation the patient recovered. The neuralgic symptom in this case had no therapeutic value. Homœopathy has been blamed many times because some physician has tried to cure with a remedy prescribed for certain reflexes having no therapeutic import; and again, because not knowing the significance of the reflexes present, has been unable to detect some important objective symptom to which they pointed.

Dr. Laning said, he had cured many cases of gastric irritation by directing attention to the bladder. *Eupatorium perfoliatum* has often produced good results by curing cystic catarrh. When the fundus of the bladder is so affected, the stomach is especially liable to be involved. On account of the peculiar arrangement of the nervous supply to the bladder, a double set of reflexes may arise from it, one extending upwards to the intestines, stomach, kidneys and head, the other to the spine, rectum and lower extremities. Bladder-irritation may give rise to diarrhœa or constipation, or to increased or diminished urination. Headaches transmitted from the stomach and intestines are far from rare. The inferior portion of the bladder being supplied by the pudic nerves from the sacral plexus, at once establishes a close relationship between the bladder and rectum. Rectal tenesmus, or a semi-paralytic condition of the rectum, sometimes results from lesions in the *trigonum vesicæ*, also pains and paralytic weakness in the lower limbs may arise from the same cause. The centres of defecation, urination and ejaculation are situated near together in the lumbar region, hence vesical lesions may, through the pudic, stimulate or inhibit, as the case may be, one or the other of the other centres. A case was then mentioned, in which fulness of the bladder at any time gave rise to nausea. Attention to this reflex and the prescription of *calcareæ phosphorica* cured a headache from which his patient had been suffering for a long time. There may be a powerful reflex sent from the lungs to the bladder or other pelvic viscera. This is illustrated by a case of enuresis nocturna in a young lady, sixteen years of age. The irritation was found to be in the pulmonary plexus, and was cured in a very short space of time, after having undergone a long course of medication by both schools of medicine. The last case reported, was one of supposed laryngeal phthisis cured by removal of a sebaceous cyst from the auditory canal. The paper closed with the statement, that the author had frequently found a knowledge of the reflexes of the greatest benefit in arriving at the cause of the difficulty in obscure

and chronic cases, and seldom in those not absolutely incurable by reason of organic changes has such knowledge failed to be of great assistance in selecting the curative remedy.

The paper being open for discussion, DR. H. P. HOLMES remarked that orificial surgery was based on a study of reflexes. At the sphincter ani we had a frequent seat of irritation, removal of which will often cure very annoying symptoms.

DR. A. L. MONROE said that we rarely had a case of dysentery, without some vesical irritation at the same time. We never have decided tenesmus vesicæ, without rectal symptoms. He also believed that there was a strong relation between the rectum and the internal os uteri. He recently had relieved a case of diarrhœa chronica, aggravated during the menstrual periods by dilatation of the cervical canal. A few months ago, he relieved a case of chronic tenesmus of the bladder by attention to the rectum. He believed that if Pratt's theories had never done anything more than open our eyes to the values of reflexes, he would have done more for humanity than any man since the days of McDowell.

DR. BOWEN, of Fort Wayne, Ind., referred to the reflex pain in the knee from hip-joint disease.

DR. T. G. COMSTOCK called attention to the importance of prepuccial abnormalities as a cause of disease in children. He reported a case of colic in a child resulting from this cause. He had known symptoms of uterine disease to arise from fissure of the rectum.

DR. H. E. SPAULDING, of Cambridge, Mass., referred to an obstinate case of what was supposed to be consumption complicated with chronic heart disease. There was some sexual irritation, arising from phimosis. Dr. Spaulding circumcised the young man, and a cure of the lung symptom followed, though the organic heart disease persisted.

DR. ARNULPHY congratulated the Society on Dr. Laning's paper. He said that wherever there was dilatation of the right heart, attention should be directed to the liver, as trouble would frequently be found there.

DR. MONROE said he did not regard the condition cited by the last speaker as reflex, but vascular.

DR. W. A. SMITH, of Morgan Park, Ill., said he did not like this way of pathological prescribing. It was far better to follow the methods of the old masters, prescribe on the totality of symptoms.

DR. J. D. BUCK said that there was a mean between two extremes. The proper way is to dwell on the totality of the symptoms which



give us the picture of the disease. Every drug has its own individuality.

DR. PEMBERTON DUDLEY said that when a member of the Institute says he is opposed to pathological prescribing, he was with him; when a member said he believes in making pathology aid in his homœopathic prescribing, he agreed with him. It is necessary, however, to have a knowledge of pathology in order to get the totality of the symptoms. If a patient comes to you with a cough of the peculiarity well known to belong to coughs arising from aural disease, unless you know pathology, you will not know enough to find out the other symptoms which belong to that cough. If a man consults you with headache, you at once make use of your pathology when you begin to question him for gastric symptoms.

DR. T. G. COMSTOCK said that a family came to him from the country with a boy who had been suffering from hemiplegia for two years. The boy had complete phimosis, the removal of which cured him. He had also cured a case of herpes circinatus by the same measure; in fact he could, would time permit, relate hundreds of cases having a similar origin.

DR. W. A. SMITH said that he would not let a case that needed operation go without one, but at the same time he would say that he had known fissures of the anus to be cured by thuja.

DR. C. S. MACK said that removing the cause of disease is perfectly proper, but it is not homœopathy.

DR. LANING said that in the discussion, medical and surgical cases had been mingled indiscriminately.

DR. R. C. NEWELL, of Austin, Ill., said that before a homœopathic remedy can do its work, all causes of irritation must be relieved. He referred to cases of asthma and hay fever, which he had greatly relieved by dilatation of the sphincter ani.

DR. STOUT, of Jacksonville, Fla., was then called on for his paper on the yellow fever epidemic in Jacksonville. Owing to the fact that his paper had been lost in the mails, the doctor was requested to make some remarks on his experience. This he did in a pleasant way, carefully detailing his experience, which was certainly enormous. The result of the homœopathic treatment of the dread disease under the judicious care of himself and colleagues at Jacksonville was a mortality of two and one-half per cent., certainly a wonderful showing.

After the conclusion of Dr. Stout's remarks, the remaining papers of the bureau were read by title and the section adjourned.

## THIRD DAY.

MORNING SESSION.—The following names were presented for membership :

Priscilla G. Myers, Aurora, Ill.; Bernard I. Arnulphy, Chicago, Ill.; Franklin C. Lefferts, Belvidere, N. J.; William B. Webb, Beaver Dam, Wis.; Anton E. Neumeister, Kansas City; Peter Diederichs, Kansas City, Mo.; Thomas Gillespie, Kenosha, Wis.; F. W. Gordon, Sterling, Ill.; C. M. Paine, Atlanta, Ga.; Sarah Smith, Council Bluffs, Ia.; A. G. Leland, Whitewater, Wis.; Charles H. Catel, Mayville, Wis.; S. D. Johnson, Fox Lake; W. H. Sanders, Chicago; E. C. Read, Blue Island, Ill.; Lucy L. Washington, Ashville, N. C.; Augustus T. McKay, West Superior; Cortland Butler Rockwell, Chicago; Charles Elias Chase, Utica.

Next came the Auditing Committee. Report accepted and committee was discharged.

Report of Committee on International Congress of 1891, I. T. Talbot, chairman.

The committee proposes that the Congress shall assemble in the middle of the second week of September, 1891, and continue its sessions for six days. The organization of the Congress and the selection of its officers are as follows: President, Dr. R. E. Dudgeon, of London; Permanent Secretary, Dr. R. Hughes, of England; Acting Secretary, Pemberton Dudley; Treasurer, E. M. Kellogg. The committee recommends: 1st. That the usual four days' annual session of the Institute be omitted in 1891, but that this Institute assemble at the same place and on the day preceding the meeting of the International Homœopathic Congress for the transaction of any necessary business pertaining to the institute. 2d. That the officers elected and the bureau committees appointed shall retain their respective positions for two years. 3d. That under the direction of the Executive Committee of this Institute, the expenses of the International Homœopathic Congress be paid from the Institute funds, and that the *Transactions* of the Congress be published and furnished to the members of the Institute in the same manner as the annual *Transactions* of the Institute are now furnished; and also to such other members or delegates of the Congress, or to such other persons or institutions as the Executive Committee may determine.

Report of the Directors of Provings laid over.

Report of the Committee on Medical Education, Dr. T. Y. Kinne, Chairman, received.

The address of the Bureau of Ophthalmology was read by Dr. James A. Campbell, and that of the Bureau of Nervous and Mental Diseases by Dr. N. Emmons Paine, in the absence of Dr. A. P. Wil-

liamson. Dr. I. T. Talbot presented the report of the Committee on Medical Legislation, which was made a special order of business for the following morning at nine o'clock. The Institute then proceeded to the annual election of officers with the following result:

*President*, T. Y. Kinne, M.D., Paterson, N. J.; *Vice-President*, J. H. McClelland, M.D., Pittsburgh, Pa.; *General Secretary*, Pemberton Dudley, M.D., Philadelphia; *Provisional Secretary*, T. M. Strong, M.D., Macon, Ga.; *Treasurer*, E. M. Kellogg, M.D., New York City; *Censors*, R. B. Rush, M.D., Salem, Ohio; T. F. Smith, M.D., New York City; C. B. Kinyon, M.D., Rock Island, Ill.; Miss M. J. Chapman, M.D., Pittsburgh; Mrs. C. T. Canfield, M.D., Chicago.

**AFTERNOON SESSION.**—Sectional meeting of the Bureau of Gynecology. At the sectional meeting of the Bureau of Gynecology, Dr. S. P. Hedges, of Chicago, presided. The first paper read was by Dr. J. W. Streeter, of Chicago, its title being, "A Plea for Early Operative Interference in Malignant Disease of the Uterus."

The author stated that 95 per cent. of the cases of malignant uterine disease began in the cervix. In two varieties—canceroid ulcer and cauliflower excrescences—the tendency is to remain limited to that portion for a considerable time. A third variety remains limited to the cervix but a short space of time, it spreading, not only by continuity of tissue, but by migration of its cells. Dr. Streeter stated that it was his firm belief that all varieties of cancer were purely local in their first stages.

He believed it a well established fact that cancer-cells could migrate through the lymph spaces and canals into the blood and establish other centres of growth. Another means of contamination of the system is by means of septic fluids produced by breaking down of tissue. Add to these the shock caused by pain, the anæmia by persistent hæmorrhage, anorexia, and imperfect digestion, and the mental depression which is common in this fearful disease, and we cannot wonder that the face soon gives evidence of the deadly disease. Early diagnosis of cancerous conditions is of the utmost importance, for it is only the early operation which gives future immunity. If we wait for the classical symptoms, pain, hæmorrhage and offensive discharge, we have waited too long for our patient's good. Pain does not come until the disease has extended beyond the limits of the cervix; hæmorrhage arises from the corroded wall of some bloodvessel, and offensive discharge from the disintegration of tissue. There are no symptoms, objective or subjective, that are pathognomonic of uterine cancer in its early stages. The microscope affords the most reliable test; next to which comes the educated touch. In doubtful cases, it is a good rule to give the patient the benefit of the doubt, and amputate the cervix, for a woman can get along very well without a cervix, while she cannot live more than two years with uterine cancer. Early diagnosis, prompt surgical

work, and well-advised constitutional treatment will accomplish wonders in this fatal disease. The three surgical procedures advised by the author were—high amputation of the cervix, hysterectomy, and curettement with sloughing by zinc chloride. High amputation is the proper measure when we are reasonably sure that the pathological process does not reach as high as the os internum. But if the cancer-cells have reached as high as the os internum, or higher, then it will be necessary to perform hysterectomy. Vaginal hysterectomy, with forcible pressure to control hæmorrhage, is as safe as laparotomy done under the most favorable conditions, that is, it has a mortality of from five to eight per cent. If there is fixation of the uterus, if the retroperitoneal glands are enlarged, or if there are other reasons for believing that the disease has extended beyond the limits of the body of the uterus, we are not warranted in putting the woman to the peril of the operation. We should never resort to hysterectomy simply to alleviate symptoms. Cure is the only warrant. In incurable cases, palliation may be accomplished by resort to the curette and zinc chloride.

DR. GEORGE W. BOWEN, of Fort Wayne, opened the discussion on Dr. Streeter's paper by remarking that he had most remarkable success in the treatment of cancer by the use of arsenic. He was in the habit of administering very large doses of the drug, even up to the extent of as much as one-fourth of a grain per day, in divided doses. He believed that this remedy, thus given, would cure ninety-tenths of all the cases of cancer.

DR. J. S. MITCHELL said that he could hardly agree with Dr. Bowen regarding the wholesale use of arsenic, though he recognized in that drug a most valuable aid in the treatment of cancerous disease. After an extended experience, he had found that the use of arsenic was limited. The only method in which he had employed the drug differently from other physicians was the application locally of a trituration, generally the 2x, sufficiently strong to cause disintegration of tissue. The resulting ulcer will heal very nicely under the use of acetic acid, carbolic acid, or calendula. He would not advise this treatment except in those cases that had gone beyond the use of the knife. He was sure that his method of using arsenic would prolong life and increase comfort. He always administered internally the same remedy he used externally, in potency from the 3x upwards.

DR. WILLIAM OWENS asked Dr. Bowen if he had ever used acetic acid as a remedy for cancer?

DR. BOWEN replied that he never had.

DR. OWEN then said that acetic acid is the only drug that has

been known in its symptomatology to produce the typical cancer-cell. He had treated a number of cases of epithelioma with acetic acid, and had some recoveries. So far as he knew, no recoveries had followed the use of the knife.

DR. O. S. RUNNELS deprecated the tendency to treat cases of cancer in the early stages by the use of escharotics and leave the knife as a last resort, when the patient is almost beyond all help. He was satisfied that as our experience increased the more readily would we resort to vaginal hysterectomy as a curative measure.

DR. E. S. BAILEY, of Chicago, said he was an earnest advocate of the removal of cancerous growths in the early stages. In the vast majority of instances vaginal hysterectomy was forced upon us when the patient has gotten into such a condition as to seriously interfere with the results. Statistics thus made are decidedly against the operation, and accordingly it has gotten into disrepute.

DR. J. W. STREETER said that he agreed fully with the different speakers regarding the importance of the use of internal remedies, but he thought that we should by operation remove the cause of the difficulties. He made a passing reference to a case of cancer in a pregnant woman, in which the woman died at about the eighth month, the child perishing also. It was a question with him whether or not Cæsarian section should be performed in these cases. A point of differential diagnosis between cancer and hyperplastic cervix with fissure, is that in the latter the mucous membrane is movable over the cervical tissue, while in case of cancer it is generally fixed. In answer to a question by Dr. Comstock, he said that he had seen a few cases of uterine cancer in the unmarried.

Dr. O. S. Runnels then read his paper on the "Rôle of the Sharp Curette."

He claimed that the sharp curette had a much wider sphere of action than is accorded it by the profession. He would not, however, regard its use as at all permissible in inflammatory conditions. If possible all the elements that are liable to leap into flame must be first removed. The mucous membrane of the uterus is not the easily destroyed and slow healing membrane it is so generally supposed to be. It is thick, resistant, almost cartilaginous, and can be penetrated, and cut away only by the exhibition of considerable force. Except at the cornua and at the entrance of the Fallopian tubes, this membrane has a thickness one-fourth the diameter of the uterine wall. Like all other mucous membranes it has the power of reproducing itself. It is because of thickness and toughness that the dull curette is so often impracticable. The symptom calling most fre-

quently for curettement is persistent hæmorrhage. Menorrhagia and metrorrhagia caused by fungous, villous, or sarcomatous degeneration of the endometrium, can be cured with the sharp curette better than by any other method. In those cases of faulty nutrition of the cervix resulting in excessive granulation, the sharp curette is the remedy par excellence. The scraping should continue until the healthy muscular tissue beneath is thoroughly reached, till all disease elements have been obliterated. Particularly is this so in cases where cervical cancer has progressed so far as to preclude the possibility of hysterectomy; when frightful hæmorrhages occur, and the necrotic tissue is emitting a highly offensive odor. These cases cannot be successfully managed without the sharp curette. Whenever uterine hæmorrhage accompanied degeneration, infiltration, hyperplasia, or chronic inflammatory changes in the mucous membrane lining the uterine cavity, no treatment affords such good results as careful and thorough curettement. The curette should be used in many forms of unyielding uterine disease where the recuperative forces seem to be swamped. Subinvolution, chronic enlargement and induration from whatever cause, in fact, every form of inveterate non-inflammatory and otherwise unimprovable uterine weakness.

The instrument with a moderately sharp edge is the one preferable to all others. It is best to use an anæsthetic. The cervical sphincter under anæsthesia usually relaxes sufficiently to allow the curette to be used without further enlargement by dilatation. The paper closed by describing the methods of using the curette, and relating the histories of some cases in the author's experience that had been cured by it.

DR. T. G. COMSTOCK said that the recommendations in Dr. Runnel's paper were most excellent and practical. He differed from him, however, in his manner of using the curette. He always used the dilator first. As for antiseptics, he had abandoned corrosive sublimate and relied upon aristol, creoline and iodoform. After the curettement he always employed an injection of a creoline solution. After this he packs the vagina with iodoform gauze, which he leaves in for twenty-four or forty-eight hours. The curette was especially applicable after abortions.

DR. J. J. THOMPSON said that it was the custom of Dr. E. H. Pratt to dilate the uterus thoroughly in these cases, wrap a pledget of cotton about a probe and wipe out the uterine cavity most thoroughly. In stopping hæmorrhages, and in other conditions, he thought that this practice would be much safer in the hands of the younger members than would be the use of the sharp curette.

DR. W. F. KNOLL, of Chicago, said that one danger of the curette in the hands of those not accustomed to it was, that small portions of

tissue would be loosened but not removed, and as a result would decay and be liable to set up toxic conditions. He thought that it was important for the uterus to be dilated thoroughly, after which the intrauterine irrigation should be used. Then the curette should be used as Dr. Runnels has directed. After the operation it was his practice to swab out the uterine cavity with a solution of carbolic acid. The after-treatment consists in the observance of antiseptic precautions.

DR. J. W. STREETER said that he too was in favor of using the dilator preliminary to the application of the curette. He used the antiseptic precautions advocated by Dr. Knoll. Like Dr. Comstock, he packed the vagina with iodoform gauze after the operation. Curettement is a simple operation for one who has skill. It is not a wise thing for a tyro, however. The more inexperienced one is in its employment the more necessary is care in the preliminary preparations. He thought that the rôle of the sharp curette would ere long be limited by the use of electricity. For the ordinary inflammations of the endometrium there was nothing better than the application of the galvanic current. In all cases of inevitable miscarriage the curette should have an extended use. Now such cases should all be treated on surgical principles, preparations being made as for a surgical operation. The patient should be put on a table, anæsthesia performed, the cervical canal dilated, rupture the membranes, and remove every portion of the decidual membranes. All this is done with aseptic precautions and the utmost care. Then the uterine cavity is washed out and the patient is put to bed. There is no pain or other reaction following the procedure, and the patient goes through under anæsthesia in a half hour what might otherwise take days or weeks. It is not often that we are obliged to produce miscarriages, but when we are, we should follow the plan just described, go about it as we would a surgical operation.

DR. C. B. KINYON was glad to hear Dr. Streeter raise the points he did ; he had always made it a point in cases of miscarriage to thoroughly curette the uterine cavity. He had often wondered whether it was not better to thoroughly clean out the uterine cavity before there was infection, than later when poisoning symptoms had developed.

DR. R. LUDLAM thought that some precautions should be adopted in the use of the sharp curette lest harm should come from its use. The moderately sharp instrument as recommended by the writer of the paper, is the best one to use, the very sharp instrument being too sharp for safety. The warning that we should not use the curette if any in-

flammatory condition is present, is certainly a good one. The curette should be employed as far removed as possible from the menstrual periods. Rest in bed for a few days beforehand should be enjoined. Dilatation before the operation is important. The dilator should be used, and not tents, for this purpose. Thus room for better manipulation and drainage is allowed. He did not favor the use of mercurial injections as an antiseptic; he rather favored *sanitas* for this purpose. After operation the use of iodoform gauze is eminently proper. He did not regard subsequent irrigation of the uterus necessary, so he did not practice it. On the second day he ordered the nurse to irrigate the vagina thoroughly.

DR. H. P. HOLMES expressed his agreement with the surgical doctrine taught by the preceding speakers, but he protested strongly against the use of antiseptics. He thought it far better to use *calendula* as advised by Bönninghausen and others of the pioneers of homœopathy, instead of all the patented preparations now in use at the present day. He himself was willing to stand by our own *calendula*.

DR. W. A. SMITH made some remarks strongly backing up the position taken by Dr. Holmes against the use of antiseptics.

DR. WILLIAM WEBSTER said that he was in the habit of using permanganate of potash injections; later, he employed *calendula* dressing.

DR. COMSTOCK said that he did not regard any of the antiseptics mentioned as either patented or secret articles.

DR. J. H. McCLELLAND would yield to no one in loyalty to homœopathy. He would, however, say that it was one thing to practice antiseptic surgery, and another to prescribe homœopathically. He then referred to the experiments made by Dr. C. M. Thomas, of Philadelphia, which went to show that *calendula* was in no sense an antiseptic, that it had not sufficient preservative powers to keep itself. The function of *calendula* is to arouse to vitality unwholesome conditions. Germicides are for a distinct purpose; they prevent septic formation.

DR. HOLMES said that he had raised the question because one gentleman recommended one antiseptic, while one recommended still another and so on. Now he questioned, if there was such a divergence of opinion, whether it was wise to trust any of them.

DR. KNOLL said that Nussbaum, in his work on "Antiseptics," mentions no less than one hundred and forty-six drugs which could be used for this purpose. Any of these could be employed in anti-



septic surgery, and yet there would be perfect adherence to antiseptic principles.

DR. STREETER thought that the whole question of antiseptics depended upon pure cleanliness. He who uses boiled water and follows perfect cleanliness, has the superlative and does not need the so-called germicides. Dr. Runnels, in closing the discussion, expressed his pleasure at the great interest manifested in the subject. The section then adjourned until evening.

**EVENING SESSION.**—Sectional Meeting in Gynæcology. The first paper read was that by Dr. Willis Danforth, of Milwaukee. Its title was "Intra-uterine Medication by Means of the Cloth Tent."

The author recommended the cloth tent as the best known means for applying medicinal agents to the cervical canal. The tent is made of ordinary bleached muslin as follows: Tear off a strip three-quarters of an inch in width, pin one end of it fast, and slowly and carefully roll it up diagonally, drawing out the point quite fine, increasing the size of the body to about the diameter of a small pipe-stem, until it measures two inches and a quarter, then cut it off and pass a needle threaded with strong twine through it, fixing a string about five inches long by which to remove it. The reason why so many fail to make these tents satisfactorily is, because they roll them too loosely, so that they lack firmness; the muslin must be pulled with extreme tension, and the tent rolled under strong pressure, in order to obtain sufficient firmness to get a practical result. With this tent we can stamp out endo-cervical catarrh in a comparatively short space of time. Saturated with iodine and hydrastis, it is especially serviceable. The tent exerts its curative effects through pressure and the applied medicament.

DR. JULIA HOLMES SMITH said that she had used the cloth tent as recommended by Dr. Danforth, but she had never obtained good results while she made the applications in her office, leaving the patient to go home immediately afterwards.

DR. STREETER said that he knew, from a moderate experience, that considerable benefit could be obtained from the use of the cloth tent. He believed, however, that, as we learn more of electricity, we would use other means less.

DR. COMSTOCK said that for many years he had not introduced a tent in his office. He had never in any of his cases met with the success that Dr. Danforth tells of; but he had not used the cloth tent after the author's manner. For the past three years he had been using galvanism.

DR. H. P. HOLMES said that he had never introduced a tent but that he felt sorry for it, when he removed it, on finding the cervical mucous membrane sore and raw. He could not understand how Dr. Danforth could insert thousands of these without a single bad result. True he dipped them in iodine, which by its astringency suppressed the inflammation. He did not see why the treatment would not produce the same results it would if applied to the nose; the insertion of a plug dipped in iodine into the nasal cavity would create great trouble.

DR. RUNNELS ascribed Dr. Holmes's bad results in the use of tents to the facts that he may have used dilating tents.

DR. MONROE said that he had never seen a case of metritis in a healthy patient or in one whose circulation was good. It may be that the bad circulation is the result of the uterine trouble, but he thought that generally the reverse relationship prevailed. During the last year or two it has been his custom to dilate the cervix, and apply his medicaments with metal sounds.

DR. WM. WEBSTER said that he had very good results from the application of cocoa butter, hydrastis, hamamelis, etc., in these cases.

DR. DANFORTH, in closing the discussion, said that if the members would follow the method as he had described it, they would find the results uniformly favorable.

A paper by Dr. G. R. Southwick, of Boston, describing cases of uterine myomata treated by electrolysis, in which suppuration had ensued, was next read. The discussion following this paper tended to the opinion that suppuration in such cases was due to lack of antiseptic precaution, or improper insulation of the electrodes.

The next paper read was that by Dr. L. A. Phillips, of Boston, on "The Surgical Treatment of Uterine Fibroids."

DR. J. W. STREETER thought that the effects of misplacements of the womb were causing more grief to gynecologists than anything else. In the search for remedial agents we are learning many practical points in anatomy, so that we are gradually getting at the correct solution of the problem. He expressed himself as against any operation on the ligaments of the uterus for correcting displacements, as such did no permanent good.

DR. T. C. DUNCAN said that in a great many of these cases the position of the trunk is habitually abnormal. By making the patient stand and walk properly, much can be done. We also find in many cases spinal hyperæmia, correction of which by galvanism does an immense amount of good.

A paper by Dr. B. F. Betts, entitled "The Clinical Aspects of Hydronephrosis," was read by title, after which the section adjourned.

**SECTIONAL MEETING IN OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.**—The Bureau of Ophthalmology, Otology and Laryngology met in sectional meeting with Dr. James A. Campbell, of St. Louis, in the chair.

Dr. D. A. Strickler, of St. Paul, read a paper describing a "Case of a Large Foreign Body in the Orbit and Nasal Cavities for Nearly Three Years, Giving Rise to but Little Inconvenience."

A man, while loading edgings in a saw-mill, was struck by a piece 6 or 8 feet long. Severe pain in the eye followed immediately, and the eye was swollen shut. After two or three days it was found that the sight of that eye was lost. The injury was at the inner side of the orbit, internal to and a little above the caruncle, passing through the upper lid. After three months' treatment he was free from pain, though the eye was still blind and the wound continued to discharge. The condition remained the same for nearly two years, when the eye became painful and the wound angry. Dr. Dockstadter, of St. Paul, was consulted, who found a hard body presenting in the wound at the upper lid. Enlarging the wound he removed a piece of wood measuring two and a half inches in length, and one and a half inches at its large and one at its smaller circumference. When brought to Dr. Strickler one month later the wound was found to communicate with both nasal cavities, so that in syringing water came from both nostrils freely, bringing with it quantities of thick pus. At the vault of the larynx, on the left side above the eminence of the Eustachian orifice, were cicatricial bands. The wound has been treated by syringing with listerine, and has improved steadily. From the direction of the wound and the size of the piece of wood, it must have broken through the os planum of the ethmoid and the septum nasi, and its inner end lodged in the sphenoidal sinus.

Dr. A. B. Norton read a paper on "Plastic Iritis," in which he described carefully the pathology, symptomatology, ætiology, etc., of the affection. By way of treatment, dry heat and atropine were recommended. The paper closed with a detailed list of the suitable remedies with their indications.

The paper by Dr. W. H. Winslow, of Pittsburgh, on "Ametropia and Neuroses," described a case in which a compound hypermetropic astigmatism gave rise to a very peculiar set of phenomena.

The patient was a young lady of twelve years. Whenever her eyes were used for near work a little while, a pain would commence in the two middle fingers of the right hand, and soon extend to the

adjacent fingers, and finally, in order, to the hand, arm, and corresponding side of the face. Finally the internal rectus of the right eye would contract and turn the eye in three or four lines. Upon ceasing to use the eyes for near vision the morbid symptoms would disappear. After proper glasses were prescribed the symptoms all disappeared, and have not been renewed for nearly a year.

"Some Observations on Errors of Refraction" was read by its author, Dr. G. C. McDermott, of Cincinnati, Ohio.

This paper opened with a number of quotations from prominent authors regarding the causes of asthenopia, which were mostly stated to be hypermetropia or nasal disease. Dr. McDermott then proceeded to describe three cases of unusual interest. Case I. was hypermetropic, but glasses did not relieve. Dr. C. A. Pauly examined her, and found an irritable sphincter ani with numerous pockets and papillæ. Attention to these cured. Case II. was a bookkeeper, who was likewise found to be a subject of hypermetropia, but proper glasses did not relieve. There were no rectal symptoms, but examination of that portion of the body showed extensive disease, as in the preceding case, and removal of which cured. Case III. was a case of asthenopia in connection with irritable rectum, treatment of the latter condition curing the patient. As the treatment of cases of neurasthenic asthenopia has so often proven so unsatisfactory, Dr. McDermott recommended that the rectum be examined in those that had resisted other methods of treatment.

Dr. H. H. Crippen's paper on "The Use of Homœopathic Remedies in Glaucoma" was the result of a carefully conducted inquiry into the results of the treatment of that dread disease by homœopathic remedies. His correspondence with a number of specialists in our school, did not show very satisfactory results from the use of internal remedies alone. The writer attributed the poor results to two causes: 1. Our provings do not give as clear a symptomatology in the domain of the eye as they should, owing to the fact that they were recorded without examinations having been made by those having special skill. 2. We do not individualize our cases closely enough. In the antipsorics, if carefully proven under the eye of the ophthalmologist, and used with strict attention to the importance of individualization, he thought we had useful remedies in glaucoma.

Dr. H. C. French's paper on "Some Dangers of Our Therapeutics" was somewhat of a companion to that by Dr. Crippen. The author's argument was to the effect that our confidence in our therapeutics had a tendency to lead us to delay operative procedures until too late. He thought it unwise to delay operation in glaucoma, as by so doing, valuable time might be lost.

Dr. James A. Campbell, of St. Louis, presented a paper on "Hysterical Amblyopia," a subject concerning which little has been written. The author reviewed the subject systematically and concisely. In speaking of treatment, he said that we must follow the same general rules as would be appropriate in hysteria proper. The remedies he mentioned were phosphorus, ferrum phos., aurum mur., pulsatilla, macrotin, onosmodium, ignatia and sepia. He had also found good results from galvanism. The importance of psychical influences was not overlooked.

Dr. W. S. Dunn, of Chicago, reported a case of "Laryngitis Sicca." The patient was a servant, æt. 22 years, who had had aphonia for three years past. There was great dryness of the throat and larynx, and a discharge of dry mucus, expectoration of which relieved the aphonia. Examination showed the pharynx to be dry, and the posterior wall covered with dessicated secretion. The whole laryngeal cavity was filled with a dry hard mass of secretion. By the use of an atomizer the whole mass was softened and thus expectorated. Her voice was quite restored after this procedure. The mucous membrane of the larynx was slightly atrophied, and there was some weakness of the laryngeal muscles. No symptom of atrophic rhinitis was present. Under treatment the case was cured in three months. After relating this case, Dr. Dunn proceeded to describe the symptomatology of this affection as observed in his experience. He made the interesting observation in one case of very marked atrophy of the vocal cords, in fact sufficient to cause almost complete loss of voice. The author had found the most satisfactory results from treatment by use of some disinfecting solution, as listerine, 3j.-3j. of water, borax, grains 10 to the ounce, Dobell's solution used in half the usual strength. After all the secretion is removed, an application of some of the glyceroles should be made directly to the diseased surface. The glyceroles he recommended particularly were the glycerole of tar, calendula or hydrastis. These are tonic to the mucous membrane and stimulant to the glandular tissue. The remedy he was in the habit of prescribing in these cases was kali bichromicum, because of its well-known effect in producing irritation and atrophy of the mucous membranes in this region.

Dr. Charles Deady reported a case of orbital caries in a young lady of nineteen.

Dr. E. W. Beebe, of Milwaukee, read a paper on the "Treatment of Incipient Cataract." The speaker thought we could offer a reasonable assurance of preventing the progress of the disorder, providing the case was taken in hand early, when there were but few opaque striæ, and the cases are carefully individualized. Delay endangered success. There could be no specific remedy for the many varieties

of lenticular opacity. Dr. Beebe thought that diabetes and lithæmia were frequent causes of cataract.

A case of membranous rhinitis was reported by Dr. Irving Townsend, of New York. This closed the report of the bureau.

**SECTIONAL MEETING IN SANITARY SCIENCE.**—The sectional meeting of the Bureau of Sanitary Science was presided over by Dr. T. Y. Kinne, of Paterson, N. J. The following papers were read and discussed: "Pure Air and Sunlight as Prophylactics and Remedies in Consumption," by Dr. H. E. Beebe, of Sidney, O.; "The Proper Arrangement of School Hours," by Dr. H. R. Stout, of Jacksonville, Fla.; "The Climate of Southwestern Texas and Its Suitability to Chronic Diseases of the Respiratory Tract," by Dr. C. E. Fisher, of San Antonio, Texas; "Special Claims of Southern California in the Climatic Treatment of Consumption," by Dr. A. R. Wright, of Buffalo, N. Y.; and "Milk and Tuberculosis," by the chairman, Dr. Kinne.

**SECTIONAL MEETING IN NERVOUS AND MENTAL DISEASES.**—In the absence of the chairman of the bureau, Dr. A. P. Williamson, Dr. N. Emmons Paine presided. Three papers having a bearing on the subject of melancholia were read. Dr. J. T. Greenleaf, of Owego, discoursed on the physical and mental symptoms of melancholia, while Dr. Lilienthal's paper treated of the various forms of delirium attendant upon this mental disease. Dr. N. Emmons Paine's paper on the "Prognosis of Melancholia" was based on 368 cases of that trouble treated at the Westboro' Insane Asylum.

Of these, 112 recovered, 3 of whom have suffered relapses; 85 were discharged much improved, many of whom have since recovered; 10 were unimproved; 23 died; and 84 still remain. The probability of recovery in melancholia is, according to these figures, 30.4 per cent. The prognosis in persons under forty years of age is decidedly better than in those older. It is unfavorable in cases presenting an hereditary taint. Cases resulting from overwork are more favorable than are others, as is also to be noted in cases arising from intemperance. Cases arising from bad habits are unfavorable.

Acute cases are favorable. The prognosis is unfavorable in chronic cases. The point on which turns the estimate of the probabilities of each patient is the condition of the mind. If the person retains a good memory, good judgment of other matters than his own physical condition and is tidy and careful in his personal appearance, his delusion may yet relax its grip and he may eventually return to active life once more. Cases of paranoia are incurable. Katatonia likewise offers an unfavorable prognosis. Cases treated at home do not result as favorably as those under hospital control; homœopathic medication

gives decidedly better results by from 5 to 20 per cent. than does that of the allopathic school.

Lip Chorea was the title of a paper presented by Dr. Edward Blake, of London. The final paper presented by this bureau was one entitled "A Clinical Study of Nervous Syphilis," by Dr. Clarence Bartlett, of Philadelphia.

#### FOURTH DAY.

**MORNING SESSION.**—The Institute met in general session to consider the report of the Committee on Medical Legislation, which had been made the special order of business. The Committee presented both majority and minority reports. The majority report was decidedly adverse to the formation of State boards of medical examiners and maintained that the formation of such boards was decidedly restrictive and un-American like. It also favored the registration of diplomas. The minority report was presented by Dr. H. M. Paine, of Albany, and was in favor of separate State boards of examiners, one for each school of medicine, in those States where it was deemed advisable by the legislators to have examining boards legalized. Dr. Paine was especially opposed to mixed examining boards, with minority homœopathic representation. The Institute, after voting on the legislative report, affirmed its adherence to the stand taken by it in this matter one year ago.

Dr. Terry, of Utica, N. Y., offered a resolution providing that hereafter the Committee on Medical Legislation should consist of one member from the legislative committees of the various State societies. This resolution was carried, but was rescinded on the following day, as it would necessitate the appointing of members who did not belong to the Institute.

The Board of Censors then reported the following applications for membership: W. B. Morgan, St. Louis; J. P. Beach, Veenah, Wis.; Howard Roy Chislett, Chicago; W. S. Harvey, Chicago; E. G. Rees, Wellington, O.; W. A. Polglase, Detroit, Mich.; O. W. Swazy, Lakeport, Cal.; Susan A. Roberts, Lemon, Ill.; Alice A. Emory, Hyde Park, Ill.; B. S. Storke, Milwaukee, Wis.; A. L. Talmage, New Haven, Conn.; R. K. Payne, Manitowoc, Wis.; George F. Courtlandt, Lasalle, Ill.; R. O. Phillips, Yonkers, N. Y.; N. H. Haight, Chicago, Ill.; Laura C. Brickley, Cincinnati, O.

The time for the next annual meeting of the Institute was brought up for consideration. It was decided to hold it in June. The Com-

mittee on President's Address then reported, commending in the highest terms of praise the scholarly production. They also reported that, through Dr. Hall, they had sent a telegram of condolence to the wife of President Sawyer.

Dr. Kinne offered an amendment to the Constitution of the Institute providing that hereafter the association should elect two vice-presidents instead of one.

Dr. Kinne also offered an amendment to the By-laws providing that each bureau should consist of fifteen members instead of ten. This was carried.

Dr. Cowperthwaite reported for the committee to whom had been referred the discrimination of life insurance companies against homœopathic physicians. Considerable amusement was created when Dr. Cowperthwaite read that portion of his report in which he quoted the chief medical examiner of a large corporation, who said that they did discriminate against homœopathic physicians because they were not taught physical diagnosis, and made no pretension to practice the same.

A motion to abolish the Committee on Medical Education (owing to the fact that the Intercollegiate Committee now looked after educational matters), and the Bureau of Anatomy, Physiology, etc., was lost by a large majority. Owing to the lateness of the hour it was voted that the addresses of the chairmen of the Bureaus of Pædology, Sanitary Science, Obstetrics, and Surgery be read in sectional meetings. The Institute then adjourned.

**SECTIONAL MEETING IN PÆDOLOGY.**—The Bureau of Pædology held its sectional meeting immediately after the adjournment of the general session above reported, the chairman, Dr. Clarence Bartlett, of Philadelphia, presiding. The first paper presented was one by Dr. Millie J. Chapman, of Pittsburgh, entitled "Examples of Homœopathic Cures in Diseases of Children." (This paper will appear in our next issue.)

DR. W. A. SMITH opened the discussion by commending Dr. Chapman's paper.

DR. J. J. THOMPSON, owing to a remark by the previous speaker, discussed the subject of orificial surgery. He did not believe in resorting to operative procedures as long as the remedies acted, but he did think it criminally wrong for us not to resort to surgical procedures when anatomical troubles were present. He trusted that the opportunity to discuss this subject of orificial surgery would present itself. He himself had the greatest respect for dietetic and medicinal



measures, and did not wish to be understood as underrating them in the least.

DR. J. E. SAWYER, of St. Paul, reported a case of chorea in a girl. The movements were particularly severe on one side. Various remedies failed. But *pulsatilla* 200, given because of the patient's temperament, effected a very rapid improvement.

DR. T. C. DUNCAN thought that the œdematous scrotum, sandy deposit in the urine, and the other symptoms in Dr. Chapman's second case called for *apis*. (Dr. Chapman said *apis* was the first remedy prescribed.) He was glad to note that the doctor pays attention to the ante-natal condition of the child's parents. If we did that more we would have better development in children. The subject of diabetes in children was of special interest to him. Such conditions in the young were brought about in two ways—one by nervous shock, and the other by errors in feeding.

DR. H. P. HOLMES cautioned against the taking of single remedies or classes of remedies highly recommended in special pathological conditions, and placing too much reliance upon them in that particular connection.

DR. CHAPMAN, in closing the discussion, said that *apis* was the first remedy given in the second case. It was continued until improvement ceased.

DR. H. M. HOBART, of Chicago, presented a paper reporting a case of polydactylism pedis, the supernumerary digits being found in a large number of patients in the same family. This paper was discussed by Dr. Sawyer, who reported a similar case to Dr. Hobart, the hereditary tendency not being so marked, however. Dr. Bartlett called attention to the fact that the amputation of the extra digits was attended by quite troublesome bleeding.

Dr. W. W. Van Baun, of Philadelphia, presented his paper entitled "Treatment of Endocardial Complications in the Diseases of Children." (This paper will appear in the August *HAHNEMANNIAN*.)

DR. J. J. THOMPSON opened the discussion by expressing himself as highly pleased with the medicinal measures recommended by the author. He thought, however, that there was a tendency on the part of physicians to abandon the use of *aconite* before resorting to it in the higher potencies. He could recall cases where the 1x had failed while the 30x had promptly cured. He deprecated strongly the tendency on the part of some physicians to discourage the child's

parents about its future. He then related some cases bearing on this point.

DR. S. P. HEDGES commended Dr. Van Baun's directions regarding the importance of heart-rest. This was a most difficult thing to control. He also advised the use of extra clothing over the chest. He had been led to this by observation of the good results obtained from such a measure in abdominal troubles. *Lycopodium* is a remedy that should not be lost sight of in the class of troubles considered by Dr. Van Baun. We would naturally be led to its use from the specific indications of the stomach, but it was of manifest advantage also in cases of real valvular troubles.

DR. A. L. MONROE told of a case illustrating the point brought out by Dr. Thompson. A young lady of twenty-five had had rheumatism when she was six years of age, and this left her with pronounced valvular disease, some aortic stenosis, and decided hypertrophy. That young lady has been told that she would not live out each year, yet she goes about as if nothing was the matter, and enjoys life just the same. She married, and has one child. Dr. Monroe said that he believed that these hypertrophied hearts gave a better circulation, as long as they lasted, than does a healthy organ. He did not believe the case he described would live as long as other people. She was very imprudent. Eventually dilatation must take place. He did not believe in using remedies in these cases. There are no symptoms to relieve. There is a material deficiency that cannot be supplied. One might as well give medicine to restore an arm that had been amputated.

DR. W. D. GENTRY said that the hypertrophied heart gave a better circulation while compensation lasted, because of its greater strength.

DR. C. E. LANING wished to emphasize the importance of Dr. Monroe's statement relative to the giving of remedies in organic heart disease without symptoms. In some cases the heart trouble may be the effect and not the cause of the symptoms present. He then related a case in which the then existing cardiac weakness was the direct result of the œdema present, relief of the latter condition at once putting the heart into good condition. Almost all of these cases go on to dilatation sooner or later.

DR. HENRY M. HOBART thought that we are too apt to look upon rest in these cases as a very light matter. As regards remedies, he thought iodine in the higher potencies would lessen the thickening of the valves. Phosphorus was a good remedy, when there

was a marked tendency to relapses from slight changes in temperature.

DR. T. C. DUNCAN said that these insidious cases of rheumatism, in which the patient complained of aching pains,—the so-called growing pains,—often gave rise to very serious conditions. Some years ago he happened to examine the chest of a promising young child in one of his families. He was shocked to find that a patient under his care could have developed such a cardiac condition as he then found.

He had classified patients into the acid and alkaline. In the acid we have lithæmic conditions, rheumatic diatheses, etc.

DR. J. E. SAWYER called attention to salicin in large doses as a remedy for acute inflammatory rheumatism, saying that it would give relief in twenty-four hours.

DR. ASHLEY said that he had found that salicin would relieve inflammatory rheumatism, but if benefit was not obtained inside of twenty-four hours the use of the drug should be abandoned.

DR. W. A. SMITH said that he had used salicin, but with unfavorable results.

DR. CLARENCE BARTLETT said that he had used salicin in large and small doses, but without any regularly satisfactory results. Its effects were disappointing.

DR. VAN BAUN, in closing the discussion, said that he generally used aconite in the 30th to begin with. The point made by Dr. Thompson relative to the not discouraging parents is a good one. The great difficulty is to insist upon proper care without causing discouragement. He had used salicin in large doses, and was satisfied that he had done harm thereby.

Dr. Clarence Bartlett, of Philadelphia, then read a paper on "Some Thoughts Concerning the Treatment of Epilepsy."

DR. TOUSLEY, of Rome, N. Y., said that the remarks in the paper showed that we cannot rely upon any specific treatment for any special disease. He expressed himself as willing to accept the experience of any honest sensible worker in his reports of cures. If one man cures his cases by operations, then he is a better operator than prescriber. He thought diet was a very important matter in the treatment of epilepsy; most of the subjects with this disease have a ravenous appetite, which must be curbed. He closed his remarks by reporting a case of convulsion, in which relief was only obtained after he had made the patient vomit an immense quantity of indigestible food that had been taken shortly before. He disa-

greed with the statement made by the essayist, that cases of epilepsy could only be regarded as cured after the convulsions had ceased to recur for two or three years.

Owing to the lateness of the hour further discussion was postponed until the following morning, at which time the other papers of the bureau were ordered to be read. (The postponed meeting of the Bureau of Pædology was not held, owing to the few members present during the last hours of the session.)

**SECTIONAL MEETING IN OBSTETRICS.**—The sectional meeting of the Bureau of Obstetrics was presided over by Dr. T. G. Comstock, of St. Louis. The first papers read were by Drs. Elias C. Price, of Baltimore, and Sheldon Leavitt, of Chicago. The subject treated of was "Occipito-posterior Positions."

DR. T. G. COMSTOCK expressed surprise at the number of cases reported by Dr. Price. He said that he himself had not had a case of that position since he gave his experience one year ago.

DR. H. M. SPAULDING deprecated immediate interference as advocated by Dr. Price. He thought nature should be given a chance to act. He had been more unfortunate than others in meeting with these cases; and during the past five or ten years they had been more frequent with him than before that time. He found that nature carries a number of these cases along very well. He would not advise interference in occipito-posterior positions, unless there was a delay that demanded it. It is not a simple thing to insert the hand into the uterus.

DR. J. C. SANDERS believed that the failure on the part of nature to convert occipito-posterior positions into anterior ones was the want of flexion. In many cases nature accomplishes the flexion herself, and does away with the necessity of interference on the part of the obstetrician. If the woman is placed in such a position as to secure flexion of the body on the head it will be found that the position will correct itself.

DR. WILLIAM WEBSTER reported a case of occipito-posterior position in which the patient had very small vulvar orifice. In passing, the perinæum was torn, the tear beginning at the anus and going upwards.

DR. SANDERS thought that if the last speaker had kept the head well up to the symphysis, he would have prevented the rupture.

Dr. Comstock then read his address as chairman of the Bureau. (This address will be found in full on page 433.) By special vote it was decided to discuss the questions considered in the address.

Following the discussion on Dr. Comstock's address, a paper was read by Dr. E. L. Smith, of Chicago, on a "Case of Placenta Prævia." This paper was discussed by Drs. Tucker, Sanders, Peck, Streeter and Ripley. The Section then adjourned.

At the session of the Obstetrical Section, held Friday morning, a paper by Dr. F. B. Righter, of Lincoln, Neb., was read by Dr. George B. Peck. It dealt with occlusion of the os uteri as an impediment to labor. Following Dr. Righter's paper, Dr. Peck presented his own paper on "Obstetric Medication." (This paper will appear in the *HAHNEMANNIAN MONTHLY*.) After explaining his reasons for writing this paper, Dr. Peck asked that it be read by title. After a few minutes spent in discussion, the Section adjourned.

**SECTIONAL MEETING IN SURGERY.**—Owing to the absence of Dr. Charles M. Thomas, of Philadelphia, the Sectional Meeting of the Bureau of Surgery was presided over by Dr. George F. Shears, of Chicago, Ill. Dr. Shears read Dr. Thomas's address as chairman of the Bureau. This address consisted of a most interesting review of the progress made in surgery during the past year.

A paper by Dr. Horace Packard, of Boston, Mass., on "Stone in the Bladder," was presented.

Speaking of the treatment of stone, the author stated that medicinal and hygienic measures offer nothing for its relief. In a gouty diathesis much may be done through medicine and hygiene to prevent such a contingency. No alkaloid or acid, so-called solvent, can have any action on the material which forms the successive layers of stone. Mineral waters can exert but little, if any, solvent action. The best of them are those containing carbonate of lithia. As to operative measures, Dr. Packard thought that Bigelow's operation is the safest and best of all methods for the treatment of by far the greater number of cases of stone in the bladder. It is a safe and practicable operation even in children. In case of very large and hard stones, suprapubic lithotomy is the preferable operation. Perineal lithotomy has practically become an obsolete operation.

Dr. L. H. Willard, of Allegheny, presented a paper reporting a series of accident cases.

Dr. H. L. Obetz read a paper on "Fractures of the Condyles of the Humerus, with Suggestions as to Prevention of Ankylosis and Gunstock Deformity."

The author took issue with those who advocated the methods of treating fractures of the condyle now in use. He regarded this in-

jury as one of childhood and youth, and the result of blows or forces applied directly to the joint. He recommended that all of these fractures should be dressed with the arm extended at the elbow-joint. The splints he advised are those made of pasteboard, adhesive plaster and egg-paste. Passive motion is not to be used except when inflammatory symptoms are absent, and then the aim is to have full range of motion at once.

Dr. J. C. Nottingham's paper on "Eczema of the Rectum" was read by Dr. D. M. Nottingham in the author's absence.

The author quoted authorities to show that rectal disease could exist without the sufferer's knowledge, and reported a case of epithelioma from his own practice in which such a condition had existed in the rectum without recognition until about four weeks prior to death. He also showed that reflex phenomena could exist as a result of latent rectal disease. After showing the analogy between the mucous membranes and the rete mucosum of the integument, he proceeded to describe his case of exudative eczema with fissures involving the rectum. The author deduced from the facts at his disposal that 1. Exudative eczema is an affection peculiar to the mucous tissue. 2. It may occur upon any mucous structure. 3. When suppressed at any point, it will appear in like structure only at a point where least resistance is offered and most favorable to its development.

The case reported was that of a man aged about forty-four years, who had been complaining of severe rheumatic pains in his legs. He had piles a number of years before. These had been removed. He had severe aching pains in the stomach at irregular intervals, and a depressed melancholy feeling much of the time. Obstinate constipation. Back, at the lumbo-sacral region, would ache, and feel numb and too weak to stand or walk, and legs would pain very much when sitting, and often when lying would feel exceedingly numb. Inspection of anus showed nothing wrong. Digital examination showed the sphincter ani strongly contracted. The sphincter was accordingly stretched. On the following day an examination with the speculum was made. The rectal mucous membrane was found swollen, appearing like knuckles of the small intestines, of a dull purple hue, protruding between the blades of the speculum at the lower part of the rectum for the most part; at other points an exudation, brownish-yellow in color, one-fourth of an inch thick, with a fissure, the bottom of which was very red, and exuded a gluey lymph. The exudations were five in number, about half an inch wide, and from two to three inches in length.

The treatment consisted of the application of a solution of carbolic acid to the fissures. *Æsculus* was given internally night and morning. Cocoa butter suppository was ordered after each stool. Improvement followed, and finally a cure. All of the reflex phenomena excepting the pains in the legs disappeared. Sexual desire, which

had been excessive, became less than normal, but this improved later.

Dr. George F. Shears reported a case of "Hydatid of the Thigh." He exhibited the specimen. Tumors of this character are exceedingly rare in the region met with in Dr. Shears's case. This closed the report of the Bureau. After some time spent in discussion, the Section adjourned.

#### FIFTH DAY.

MORNING SESSION.—The Board of Censors reported favorably on the following applications for membership: E. L. Smith, Chicago; S. N. Brayton, Buffalo, N. Y.; J. P. Webster, Delavan, Wis.; E. H. Parker, Eau Claire, Wis.; W. R. Anschutz, Nicholasville, Kan.

The Intercollegiate Committee then reported. The following reforms in medical education had been accomplished by it:

1. Advanced requirements in preliminary examinations. 2. Extension of the course of study and attendance upon lectures from two to three years. 3. Extension of the lecture term from four and five months to not less than six months. 4. The establishment of a better curriculum. 5. The consideration, in some cases the adoption, of a four years' course of study. The recommendations of the Committee are the following: 1. That the profession aid the colleges in their efforts to secure higher medical education. 2. By sending men and women to our colleges of superior qualities and thoroughly prepared. 3. By sending students to the best rather than to the cheapest colleges. 4. By using their influence to secure for medical colleges contributions and endowment funds.

The Committee formulated the following plan as to the requirements for entrance to our colleges: 1. English composition, by writing at the time of the examination an essay of not less than two hundred words, by which may be judged the writer's attainments in grammar, spelling and writing. 2. Arithmetic as far as square root. 3. Geography, physical and political, such as is contained in advanced school geographies. 4. History; the outlines of history of modern civilized nations, especially of American history, such as is contained in the ordinary manuals of history. 5. Physics. 6. Biology and physiology. 7. Chemistry as presented in Miller's *Elementary Chemistry*. 8. Botany as found in the elementary manuals.

The report of the Committee was accepted and its recommendations adopted unanimously. The following resolutions were then passed:

*Resolved*, That the American Institute of Homœopathy endorses

the action of the Intercollegiate Committee, by which four years shall be made the required term of medical study, and that studies of the first year shall be definitely arranged to include the necessary preliminary studies requisite to more advanced medical instruction.

*Resolved*, That it is the duty of every member of the Institute to assist and sustain the medical colleges in their efforts.

These resolutions were carried unanimously, with much enthusiasm.

The subject of medical legislation came up once more for consideration. After considerable discussion it was decided to refer all matters pertaining to the formation of a Committee on Medical Legislation to a committee of three, consisting of Drs. McClelland, Sawyer and Duncan.

After transacting some further routine business, the Institute adjourned to meet at Atlantic City, in 1891, in conjunction with the World's Homœopathic Convention.

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## CORRESPONDENCE.

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### TO THE EDITORS OF THE HAHNEMANNIAN MONTHLY:

In the article on lycopod. cl., by Dr. Korndorfer, in the May number, he mentions arsenicum and coccul. as remedies for sea-sickness.

I would like to add four more remedies to this list, which I have also verified by practical experience during a sea-voyage, viz.: Borax, nux vom., petroleum, and sepia. The worst case was cured by borax. The lady had been sick ever since leaving Germany (Bremen), and when off Newfoundland was so much reduced she could not stand; the storm still continuing. She gave me the symptom: "Every time the ship goes down, everything in me comes up." Two doses of borax 2c. cured in two days.

Fraternally,

F. H. LUTZE, M.D.

CHESHIRE, N. Y., June 4, 1890.



# GLEANINGS

## GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

**CHOREA AND RHEUMATISM.**—A case of severe chorea attended by paresis and loss of speech for eighty-one days, and complicated with periendocarditis and a great development of fibrous nodules. Death after eight and a half months' illness. Dr. Henry Ashby records a case of this character in a girl of nine years. There was a strong rheumatic history in both parents. Premonitory symptoms, such as excessive fidgetiness, made their appearance three or four weeks previous to the choreic condition. Apart from the severe chorea from which the patient suffered, there was a continuance of the "rheumatic state" for several months, during which time there was joint tenderness, shooting pains, acid perspirations, continuous crops of "fibrous nodules," patches of erythema, and repeated attacks of peri- and endocarditis. An unusual feature in the case was the distressing cardiac neuralgia, the pain over the heart appearing to be intense, and the sense of constriction round the chest being very marked and difficult to relieve. There was doubtless a laboring ill-nourished heart struggling with its load. The large crop of fibrous nodules, which were mostly situated over the prominent parts, and where, in the choreic state of the patient, friction would be most intense, certainly pointed to the intensity of the "rheumatic state," and the consequent probability of recurrent attacks of peri- and endocarditis. As insisted upon by Dr. Cheadle, in the rheumatic state there is a special liability to irritative lesions of the fibrous tissues (seen in this case in the nodules), which are caused by a proliferation and cell-infiltration of the fibrous tissue. The significance of the occurrence of nodules cannot be over-rated, if, as Dr. Cheadle insists, there is a close relationship between the fibrous nodules and the peri- and endocarditis. The nervous features of the case were of peculiar interest. For nearly three months the patient did not speak, being perfectly sensible and rational, any attempt at speaking, especially when the chorea was at its worst, made the involuntary movements of the face and neck more violent. The cause of the loss of the speech was doubtless due to a loss of control over the muscles of the tongue and lips. This was also manifested in the difficulty of masticating the food. The power of speech returned entirely, and was retained up to the time of death. Other peculiar features of the case were well-marked retraction of the jaw and the over-action of the flexors of the fingers. The case illustrates in a remarkable manner the close association between chorea and the rheumatic state, and the damage which the heart may suffer in the young without the patient suffering from a typical attack of articular rheumatism. The repeated attacks of endo- and pericarditis were chiefly instrumental in bringing about the fatal termination. The treatment was not satisfactory. Large doses of both chloral and bromide altogether failed to promote sleep or to quiet the constant movements of the limbs. The sedative which answered the best was "nepenthe," given in large and increasing doses. During the later stages of the heart trouble digitalis and all the heart tonics failed completely.—*The Medical Chronicle*, May, 1890.

**ALCOHOLISM AND STRYCHNIA.**—Dr. A. E. Pambro records seven cases of alcoholism and dipsomania treated with strychnia. He recommends the drug as perfectly reliable in this affection, and says that it not only cures the solitary attacks, but also the desire or craving for alcoholic beverages. He has also noticed benefit follow its use in delirium tremens. In moderate cases he gives one-thirtieth of a gramme hypodermically; in severe cases, one-fifteenth of a gramme. Smaller doses, he says, have no effect. During the treatment the patient loses all desire for alcohol. Whether the cure is only for some time, or whether it lasts forever, is a problem yet requiring solution.—*St. Petersburg. Med. Wochenschr.*, 12, 1890.

**TREATMENT OF SCURVY BY A STRICT MILK DIET.**—Tchelzoff treated one of his scorbutic patients according to the rules laid down in the text-books, but failed to relieve him. The patient then requested that he have the privilege of treating himself according to the custom in his province, by an exclusive milk diet, no other food being allowed. He soon recovered. At Rybinsk, on the Volga, Tchelzoff met with a severe epidemic of scurvy, and he cured twenty-eight cases in various stages of the disease by a strict milk diet. The action of this treatment is shown at first by disappearance of the pains and the fever. Then the swelling and induration of the limbs, the muscular pains, and the rigidity and tumefaction of the articulations, the cutaneous ecchymoses, and the affection of the gums, gradually disappear.—*Sem. Med.*, 16, 1890.

**DIABETES MELLITUS IN CHILDREN.**—Stern has collected from pediatric literature no less than one hundred and seventeen cases of diabetes occurring in childhood. While the disease is of most frequent occurrence in male adults, in childhood it attacks girls more frequently than the boys, in the proportion of five to three. As to etiology, heredity takes first place. Not only do the children of diabetics, but also those of neuropathic disposition become diabetic. Next to heredity he found it most frequently to result from severe acute disease, as gastric catarrh, morbus maculosus Werlhofii, typhoids, malarial diseases, measles, and in connection with the furuncular diathesis. In several cases unsuitable food was certainly the cause of the glycosuria. Concussion of the brain and "catching cold" are also causes. The disease varies greatly in its course and symptomatology in different cases. Its beginning is often difficult to trace. Among the symptoms may be noted menal inactivity, anxiety, a fruity odor to the breath, poor sleep, irritability, frequent urination and great thirst. Less regularly, present are dyspeptic troubles, fulness of the head, bulimy and great desire for sweets. The specific gravity of the urine may be increased to 1042, and the quantity to from 1500 to 2400 centimetres in the twenty-four hours. Albumin is rarely found. There is great debility, emaciation, anæmia, frequent vertigo and epistaxis. The skin is dry and hot, with hardly any actual rise in temperature; there is a tendency to furuncles, ulcers and abscesses; the tongue is dry and coated; the saliva may contain sugar, which, changing into lactic acid, may affect the teeth injuriously. Sometimes thirst and hunger are abnormally small. There may be vomiting, sour eructations, and constipation. The respiratory organs are often affected toward the end of the disease. Most of the cases die of marasmus or diabetic coma. Some succumb to pneumonia. Cataract in children should lead to an examination of the urine. The disease may last from two days to several years. When it has lasted more than a year, a cure can hardly be expected. The younger the patient the more rapid is the course that it pursues. In infants it may be necessary to use the catheter in order to get sufficient urine for examination. Regulation of diet promises better results than does reliance on medicinal treatment.—*Wien. Med. Presse*, 16, 1890.

**DIAGNOSTIC ERRORS IN CASES OF BILIARY CALCULI.**—Cyr calls attention to the fact that in biliary calculi we may have no colic whatever, and in its place a sensation of malaise, especially about the epigastrium and right hypochondrium. Thus, the patient is supposed to be suffering from dilated stomach, neurasthenia, hypochondriasis, etc. This form of biliary lithiasis is sometimes seen in women, especially those at the change of life. In other cases, the pain does not remain limited to the region of the liver and gall-bladder, but is especially felt as a gastralgia. Or, it may be felt in the lumbar region, thus giving rise to the diagnosis of nephritic colic. In other cases, the pain is felt in the chest, and is diagnosed as intercostal neuralgia. Again, it may be felt below the umbilicus, and so the disease simulates a peritonitis, metritis, ileus, etc. In relation to gall-stone colic, the pain may be only light and transitory, and thus mistaken for a mere neuralgia; or, it may set in with excessive violence and suddenness, simulating an eclamptic or hysterical attack, or a case of poisoning. Fever may be either persistent or absent. Some anomalous cases show such grave symptoms that they are mistaken for adynamic bilious or typhoid fevers. We are supposed to be dealing with cholelithiasis, when we meet with jaundice, and an examination of the feces shows gravel if not also calculi.—*Arch. Gen. de Med.*

**ACUTE PULMONARY ŒDEMA.**—German authors consider the cause of acute pulmonary œdema to be a rapid exhaustion of the left ventricle. Bouvert believes that it emanates from trouble in the vaso-motor innervation in the domain of the

pulmonary nerves. Huchard has met with it in association with all affections having increased arterial tension, as affections of the aorta, arterial cardiopathies, interstitial nephritis, etc. Death sometimes takes place very rapidly in these cases. Digitalis is too slow in its action, and atropia too frequently disappoints. Most reliance can be placed upon injections of large doses of caffeine or strychnia, or perhaps on squills. As a last resort, we have a big venesection.—*Sem. Medicale*, 18, 1890.

**CACTUS GRANDIFLORUS IN HEART DISEASE.**—Dr. Orlando Jones publishes his experience of cactus grandiflorus, which he claims is likely to prove a useful adjunct to our resources, especially in asthenic conditions of the heart. Digitalis, strophanthus and convallaria are not always reliable in the varied conditions of the heart which we daily meet.

The action of digitalis is not infrequently disappointinging when we are dealing with a feeble heart, especially if that feebleness is excessive and of long duration. In such instances cactus grandiflorus may fill a gap where other remedies appear to be lacking.

The action of this remedy seems to be the very opposite of that of digitalis, that is, in the final stage it strengthens the heart.—*British Medical Journal*, January 11, 1890.

**ACTINOMYCOSIS ATTACKING THE BRAIN.**—The rare affection, actinomycosis, has attracted considerable attention during the last two or three years. Published cases have hitherto chiefly come from continental sources, although two have occurred in London within the past two months. The diagnosis is always obscure, and its verification can only be assured by the recognition of the characteristic "ray fungus" in the discharge from abscesses or the sputum, the rosettes being best stained by Weigert's modification of the Gram method. The lung is the organ most generally attacked, and cases of actinomycosis attacking the brain are extremely rare, only six cases being on record. In the *Deutsche Med. Wochenschrift*, No. 16, an interesting case of this kind is reported by Dr. Orlow. The patient was a woman aged thirty, who was first seen in December, 1887, with the history of having been ill for one year, her illness commencing with a swelling on the left side of the neck, followed by other painful tumors over the large trochanter and tibio-tarsal joint. She also suffered from right-sided pleurisy. On admission to the hospital, several small abscesses were found over the above mentioned localities, as well as over the upper part of the right arm, and in the pus obtained from these abscesses characteristic actinomycotic granules were discovered. On January 22, 1888, the patient was seized with vertigo, and spasmodic contraction of the fingers of the right hand. Similar attacks occurred on the following days, the contractions gradually passing upwards until the face muscles also were affected. The patient vomited frequently, and as the attacks increased in extent loss of consciousness became more and more complete. She continued in much the same condition for a month, at times showing some slight improvement. At the end of that time, however, the right arm became paralyzed, followed by loss of power in the right leg, and loss of sensation down the right side. The convulsive seizures gradually grew more severe, and passed over to the left side. The patient gradually sank, and died March 7th. The symptoms pointed to some cortical affection, and this proved to be the case, for at the necropsy, in addition to the superficial abscesses already mentioned, an abscess was found in the left hemisphere of the brain, situated immediately below the membranes, and involving the ascending frontal and ascending parietal convolutions. The pus from this abscess contained actinomycotic granules. The right lung was also affected, but the other organs were healthy. This is the first recorded case in which actinomycosis attacking the brain produced such pronounced motor and sensory disturbances, and is consequently especially interesting from a clinical point of view.—*The Lancet*, May 17, 1890.

**LOCAL ACCIDENT FROM THE USE OF COCAINE.**—Bosquet reports that he operated on a man of 32 years for hypospadias. He injected on either side of the penis a fourth of a syringeful of a solution of cocaine 1:20. The operation was painless, but, when putting on the bandage, it was found that the parts had lost their vitality. Later, in an operation for phimosis, cocaine was used. The operation was painless, but the cellular tissue of the penis became very oedematous, the skin took on a bronzed hue, and after a few days gangrene set in. Strict antiseptic methods were followed, so all the blame must be laid to the cocaine as the cause of the trophic disturbances.—*Sem. Med.*, 18, 1890.

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**OCULAR COMPLICATIONS OF MALARIA.**—Dr. de Schweinitz, in discussing the various diseases of the eyes which appear in association with malarial toxæmia, concludes: Malaria may originate, 1. An ophthalmia of the intermittent type, which sometimes replaces the ordinary manifestations of the disease. 2. A form of keratitis properly described as "malarial keratitis," and quite distinct from those types of corneal inflammation which are simply associated with intermittent fever. 3. Various functional ocular disturbances, amblyopia, paresis of accommodation, changes in the field of vision, even hemianopsia and night blindness. 4. Gross changes in the interior of the eye, optic neuritis, optic atrophy, retinal hæmorrhages and hæmorrhage into the vitreous.

In the event of the appearance of any of the disorders of the fourth class, it is necessary, before ascribing it to malaria, to eliminate rheumatism, syphilis, chronic Bright's disease and chronic hepatitis, and, in so far as atrophies are concerned, the influence of quinine. In any doubtful case, especially in larvate forms of intermittent, and, indeed, in all cases, a careful examination of the blood should be made with the hope of determining the presence or absence of the corpuscles of *Leveran*. It remains to be shown what relation the character and number of these bodies bear to ocular diseases attributed to malaria.—*Medical News*, June 7, 1890.

**OCULAR DISORDERS AND THE ESTABLISHMENT OF MENSTRUATION.**—Ocular difficulties may supervene at the time of the establishment of menstruation, and also appear at each monthly period after its establishment, especially in the event of dysmenorrhœa, while amenorrhœa, sudden suppression of the menses and the menopause are well-known causes of serious intraocular lesions. Between the ages of thirteen and sixteen, and sometimes earlier if the subject is precocious in development, the changes which the establishment of the menstrual molimen brings forth in the youthful organism are of the utmost importance, and the eye, in common with the organs, is subject to a variety of disorders.

These may be slight, and consist in indistinct vision, muscæ accommoditis, and often are attributed injudiciously to eye strain, especially if minor errors of refraction coexist; or they may be severe, and comprise gross changes in the cornea, iris, vitreous, choroid, retina and optic nerve.—*University Medical Magazine*, June, 1890.

**INCOMPLETE UNILATERAL DEAFNESS FOLLOWING MUMPS.**—Moure reports two cases of incomplete unilateral deafness following mumps (*Annales de la Polyclinique de Bordeaux*). In one case the lesion seemed to be in the conducting apparatus, and the author believed, as the membrane revealed nothing abnormal, that there had been an exudation into the tympanic cavity, resulting in interference with the action of the fenestra; hence the explanation of the irremediability of the deafness.—*American Journal Med. Sciences*, June, 1890.

**EFFECTS OF NAPHTHALIN ON THE EYE.**—Dr. Kolinski points out that naphthalin, which has been coming much into use from the powerful effect on the micro-organisms which exist in the intestines in some kinds of diarrhœa, also possesses the property of producing changes in the nutritive power of the blood, thus being able to set up degeneration of the bloodvessels. As the eye is one of the most vascular organs, it is one of the first to show any of the changes induced by interference with the nutritive property of the blood.

Naphthalin, according to Dr. Kolinski, first causes small extravasations in the choroid and in the ciliary body, then ecchymosis and white patches in the retina, and finally cloudiness in the lens and crystals in the vitreous humor.

We may add to these remarks, published by the *Lancet* and in *Von Græfe's Archives*, that it has long been known how much influence is exerted on the eye by disturbance of the digestive organs, and especially by affections of the liver, which may actually produce cataract, the latter disappearing when the liver symptoms are cured. We know also how strongly certain medicaments, such as santonine, morphine, hyoscamine, etc., act on the organ of sight.

The Polish physician has done well to draw attention to naphthalin in this respect.—*Canadian Practitioner*, June, 1890.

**CHRONIC PURULENT OTITIS MEDIA IN DRUNKARDS.**—Noquet has made a number of observations upon the above-named subject (*Revue de Laryngologie*). The result of the study shows that the evolution of such otides is rapid, that the nerve centres are simultaneously invaded, and the extent of the disorders under the influence of alcohol is great. Alcohol, in this form of otitis, has a deplorable influence on the course of the disease, as it has on all other maladies.—*American Journal Med. Sciences*, June, 1890.

**MASSAGE OF THE MEMBRANA TYMPANI FOR CHRONIC CATARRH OF THE MIDDLE EAR.**—In the course of a paper by Dr. Adolf Brenner on this subject, he states that Prof. Lucae some years ago recommended as a new method that of compressing the air in the external meatus, thus pressing in the drum head; and of rarefying the air in the external meatus, thus drawing out the drum head. He, however, soon gave up this method, because, as he said, it gave rise to hyperemia or inflammation.

Delstanche has since taken up this idea and recommended it chiefly in cases of sclerosis or dry catarrh, and has suggested an instrument by which the drum head, and with it, of course, the ossicles, can be moved up and down.

Hommel has practiced with varying results, passing the tragus with the finger into the meatus at the rate of 120 times per minute, repeated several times a day for one or two minutes.

In 1884 Lucae recommended the use of what he called a "pressure probe," for the treatment of some cases of chronic catarrh of the middle ear. This instrument consists of a probe with an enlarged concave end, and attached to a weak spiral spring. The end, covered with cotton, wool or gum, is passed on to the short process of the malleus, and moved up and down two to ten times, of course under guidance of the frontal mirror. In this manner one moves the chain of ossicles, breaks down any slight adhesions and loosens the joints of the ossicles. In some cases this is not at all painful, in others, however, very much so. The local application of cocaine does not seem to relieve the pain at all. Lucae only uses the probe in those cases of chronic catarrh in which Rinne's method is negative and in which speech is imperfectly heard. He has only tried it in those cases in which the use of Politzer's method and the Eustachian catheter had failed to improve the hearing. Out of 44 recorded cases, Lucae failed to improve the hearing in 7 cases. There was slight improvement in 14, much improvement in 10, and in 13 the improvement was very marked. The writer has used Delstanche's and Lucae's instruments in many cases in the past two years, but has always employed the catheter and Politzer's bag in conjunction with it.

Out of 64 cases the hearing was made decidedly worse in 1, in 43 cases there was no change, and in 20 cases there was well-marked improvement.—*British Medical Journal*, June 24, 1890.

**A NEW TEST FOR INSUFFICIENCIES OF OCULAR MUSCLES.**—Dr. E. A. Maddox, the originator of the obtuse prism test for heterophoria, proposes another method for detecting latent deviations of the eyes, which is even simpler and perhaps more accurate than his first. The principle of the test depends upon the property of transparent cylinders to cause apparent elongation of any object viewed through them, so that, in looking at a distant flame with a glass rod before one eye, it appears converted into a long thin line of light, so dissimilar from the flame itself, as seen at the same time by the other naked eye, that there remains practically no desire to unite the two images, whose relative position indicates the conditions of equilibrium in the two eyes. The length of the rod is immaterial if not less than one-third of an inch; the best thickness is a quarter of an inch.

To test for heterophoria, stand the patient at 6 meters from a small flame, such as a gas jet turned down till it is only a quarter-inch high (or a more distant street lamp will do as well), and place the rod horizontally before one eye, a colored glass before the other. If the line passes through the flame, there is orthophoria as far as the horizontal movements of the eye are concerned. Should the line lie to either side of the flame, as in most people it will, there is either latent convergence or latent divergence manifested; the former if the line is the same side as the rod (homonymous diplopia); the latter, if to the other side (crossed diplopia).

For vertical deviations, hold the rod vertically so as to produce a horizontal line of light. If the line pass through the flame, there is no tendency to vertical deviation, but if it appear above or below it, there is hyperphoria of that eye which sees the lowest image, i.e. that the flame is lowest; there is a tendency to upward deviation of the naked eye if the line is lowest, of the eye before which the rod is.

**VERTIGO AND MENIERE'S DISEASE.**—In the course of a short and interesting paper upon vertigo, Dr. Davidson calls attention to the vertigo which arises from other causes than actual disease of the semi-lunar canals which should properly be called "aural vertigo," and not "Meniere's disease." The cases described by Meniere were mostly, if not all, cases of disease of the semi-lunar canals themselves. Anything that leads to undue pressure (chronic catarrh of the middle ear, wax in the external meatus pressing upon the tympanum, syringing the ear, etc.) may lead to vertigo. Contradictory sensations are converged by the two labyrinths to the brain, and consequent giddiness results.

As brains differ in sensitiveness, vertigo does not occur in every case. He does not consider the vertigos described as "laryngeal and nasal" to be true peripheral, but rather to be cerebral vertigo. In all such cases it will be found that there has been prolonged and violent sneezing or coughing, which has disturbed the circulation in the brain so as to have directly, by congestion, irritated the centre for equilibrium. Possibly some of the nasal cases may really be cases of labyrinthian vertigo through the Eustachian canal.—*Journal of Laryngology and Rhinology*, May, 1890.

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## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

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**WIRING THE PATELLA FOR SIMPLE FRACTURES.**—In contrast with Bull's article, an abstract of which appeared in our last number, are two, by Phelps (*New York Medical Journal*, May 31 and June 7, 1890), and Fluhrer (*Medical Record*, June 7 and 14, 1890), presenting a number of cases and advocating operative interference in this lesion. Phelps confines his report to simple fractures, excluding those which are compound and always require wiring, and to those of recent date. His experience extends over five years, and all cases excepting four have been operated. In two of these the ordinary treatment was relied upon with unsatisfactory results. Of the forty-two cases operated, in forty-one "bony union" was obtained with varying degrees of flexion; in one, where the fragments could not be coapted, there was ankylosis and a strong limb. The operative technique is insisted upon and minutely described, the key-notes being absolute asepsis and delicate manipulation of the joint. The preliminary treatment consists of immobilization and hot or cold applications as indicated. Cold is to be used only where there is heat and tenderness and liability to inflammation, and should be continued but three or four days. If there is much contusion, heat is to be preferred. The dry roller should be substituted as soon as possible, and always a couple of days prior to operation. This has been done from the seventh to the fourteenth day on an average, the interval being longer in proportion to the amount of laceration and contusion, which would delay union of the soft parts. In most cases the tenth day will be the most favorable time. The antiseptic precautions consist of thorough cleansing and wrapping the limb in bichloride towels (1 to 1000) from the groin down to the foot. The hands and instruments are treated in the usual manner. Irrigation is kept up continuously with sublimate. The incision is transverse and directly over the break, and the joint is freely laid open to the full extent of the laceration in the synovial membrane. The cavity can thus be thoroughly examined and cleaned. Drainage is made by a tube on the outer side at the most dependent point. The tube is put in place by a trocar and cannula, which is large enough to let it pass. In almost every instance shreds of tissue will be found hanging down between the fragments. These are carefully detached with a scoop so that the bony surfaces can be brought in direct contact. The fragments are then drilled and held together with heavy wire of absolutely pure silver. One wire will usually suffice, although two may be needed. The drill hole should go through the bone, and in consequence enter the joint; it can be buried in a groove cut in the cartilage. The ends are twisted, cut short and turned into the interosseous sulcus. The next step is to close the joint cavity by a carefully applied catgut suture, which unites the capsule over the patella, and the deep fascia and synovial membrane on either side. Union of the superficial wound, with capillary drainage, completes the operation. The limb

dressed antiseptically from the groin to the foot, and put on a posterior splint with the whole extremity in a wire cage. The drains are removed the third day and one more dressing completes the healing. Immobility should be maintained, as a rule, for three weeks, and the patient kept in bed a week longer. The writer has collected one hundred and sixteen cases operated on in New York during the last six years, with but one death, and this not referable to the operation. In the discussion that followed the reading of this paper, at the meeting of the Bellevue Hospital Alumni, the general tendency was against the universal recourse to wiring; in other words its restriction to selected cases, those of refracture and compound fracture preferably; against its being practiced by the average surgeon, and particularly by men not well versed in antiseptic details. Fluhrer reports sixteen cases. His technique, also very accurately described, differs in no essential respects from that already given. He leans toward the vertical incision and the subsequent removal of the wire sutures.

**COMPOUND COMMINUTED FRACTURE OF THE PATELLA.**—In the *British Medical Journal*, May 24, 1890, Altham reports a case of compound fracture of the patella, with comminution and avulsion of the ligamentum patellæ. The entire bone and ligament were removed, together with small pebbles and dirt, the joint thoroughly cleaned and drained posteriorly, and the wound accurately united. The result was very good, the joint freely movable; patient could go up and down stairs, the only thing noticeable in the gait being a slight swinging movement of the leg as it was brought forward.

**TREATMENT OF FLAT FOOT BY SUPRAMALLEOLAR OSTEOTOMY.**—Willy Meyer reports two cases treated by this method, as advocated by Trendelenburg and Hahn. He has also done the same operation in two cases of traumatic valgus following Pott's fracture. He reviews the different operative procedures practiced for the correction of this deformity: (1) removal of the scaphoid, at times together with the head of the astragalus, and sawing through the whole tarsus (Golding-Bird and Davy); (2) chiselling off the cartilaginous surfaces of the astragalus and scaphoid at Chopart's joint, and pegging the bones together (Ogston); (3) astragaloid osteotomy, or the removal of a wedge-shaped piece from the enlarged head and neck of the astragalus (Stokes); (4) excision of the astragalus (Weinlechner); (5) excision of a portion of the muscles, fascia and skin of the sole, with union of the ends, to shorten the "girders" (Phelps); (6) supramalleolar osteotomy of the tibia and fibula (Trendelenburg), and (7) of the tibia alone (Hahn). The last-named procedures remove the cause of flat foot according to either of the main theories regarding its causation, i.e., displacement of the astragalus downward and inward on the articular facets of the os calcis, from tired muscle and stretched ligaments (Lorenz and Royal-Whitman); or inward displacement of the arch from exaggerated rotation of the astragalus (Von Meyer). His operations were performed as follows: The fibula was chiselled through a half-inch above the tip of the malleolus; the tibia was then partly cut through and broken by forcibly turning the foot inward. Injury to the posterior tibial is thus avoided. The wounds were dressed and the limbs incased in plaster to the middle of the thigh. The knee was flexed to a right angle to relax the calf muscles, and the foot put in an over-corrected position. The results were very satisfactory, the legs showing but a slight bowing in the photographs. The writer gives the following conclusions:

1. Supramalleolar osteotomy seems to be the most rational operation for the radical cure of flat foot, as its object is to correct the deformity without interfering with any of the tissues of the foot proper.
2. In advanced cases it will probably give a good result, too, and may be combined with Ogston's operation (Hahn).
3. If osteotomy has been performed, the position of the foot can be easily corrected.
4. The tibia and fibula should be cut close to tibio-tarsal joint, and the latter not injured.
5. As soon as the foot is pressed into a normal position it will be seen that the arch is completely restored.
6. Between the tenth and twelfth days the splint should be removed and the position of the foot re-examined, and, if necessary, definitely corrected.
7. The patient may get up in about five to six weeks after the operation.
8. A slight over-correction may be advisable to guard against recurrence, and the

necessity of wearing the supporting brace advised by Trendelenburg.—*N. Y. Medical Journal*, May 24, 1890.

**CONICAL STUMP AFTER AMPUTATIONS IN CHILDREN.**—Powers calls attention to this sequela as one of rather frequent occurrence after amputations in children and adolescents, and justly emphasizes it as of prognostic value and to be borne in mind, from a medico-legal point of view. If such deformities are liable to occur, the patients should be warned of their probable occurrence, and the surgeon thus protected from unmerited censure;juries also may take into consideration the probability of subsequent operative interference becoming necessary in deciding on their verdicts. Such conicity is more liable to occur in the leg and arm, less so in the forearm and thigh. The practical deduction is, that in amputations in the young the flaps should be unnecessarily redundant. This conicity is due to a physiological growth of the bone from the predominant epiphysis, the one that appears first and ossifies last. This bony growth surpasses the development of the soft parts, hence the projection of bone.—*Medical Record*, June 7, 1890.

(We have met with two such cases: one, a thigh amputation we had done on a boy of eight years for extensive knee-disease; a large hyperostosis developed at the end of the bone, besides elongation. Another case, aged twenty-four years, amputated by a surgeon of repute, a number of years ago, just below the old point of election in the leg. We re-amputated a few weeks since, before the class at Hahnemann College, for a typical conical stump.—Ed.)

**TETANUS.**—Stroup reports, in the *University Medical Magazine*, a case in which tetanus followed a nail-wound of the knee. Steaming, bromide, chloral, chloroform, morphia and cocaine, at most, gave but temporary and partial relief. When the man appeared to be dying, a tenotomy knife was pushed into the cicatrix and a deep incision made. The muscles immediately relaxed, and the patient recovered.

Bidder treated a similar attack following crushed fingers, by washing and dressing the wound with carbolic solutions, while chloral was administered internally. Improvement being but slight and the wound looking unhealthy, 2 per cent. carbolic solution was injected hypodermatically around the edges. Healthy granulations and healing followed, and the spasmodic symptoms disappeared.—*Deutsche Mediz. Wochenschrift*, March 6, 1890.

**APPENDICITIS IN THE SCROTUM.**—Monks reports the case of a boy thirteen years of age who presented a scrotal tumor, painful and red in one spot. This had begun two month previously as a small "bunch" in the groin. On careful palpation, a lump about the size of an olive could be made out, with a narrow neck running up into the external ring. There was no cough impulse, and aspiration withdrew a few drops of yellowish fluid containing pus cells. Poultices were applied, and the swelling gradually subsided until all inflammatory symptoms disappeared. An incision then revealed a cord-like body closely adherent to the sack. On drawing it down the cæcum came into view. The appendix was tied off, the edges inverted and stitched, and the stump and cæcum returned into the abdomen. The rings and canal were closed in the usual manner.—*Boston Medical and Surgical Journal*, June 5, 1890.

**COCAINE ANTIDOTES.**—S. Mitchell (*Medical Record*, May 31, 1890) has found that while ammonia, digitalis and brandy, will relieve the milder toxic manifestations of cocaine poisoning, they signally fail when these symptoms are superseded by severe precordial pain, weak and rapid pulse, sighing respiration, borborygmus and belching of wind, muscular rigidity, and later, paralysis of the whole body, except the brain which is unnaturally active. In such a case, he used a large tea-cupful of clear coffee, and has found it equally efficacious on subsequent occasions. It can be administered cold or hot. (He makes no mention of amyl nitrite.)

I. Gluck (*Ibid.*, June 21, 1890) advocates dissolving the cocaine in a 3 per cent. solution of phenol. This, he claims, prevents the toxic effects of the former drug and renders the solution stable; as is well known, such solutions otherwise lose their anæsthetic effects after twenty-four hours. Phenol, besides, has a certain anæsthetic power of its own, forms a superficial eschar which prevents absorption of the cocaine, destroys bacteria, fungi, etc., prevents decomposition in the solution, renders it aseptic and wards off reactive congestion.



# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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CONDUCTED BY

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**AGGRAVATIONS AND AMELIORATIONS FROM MUSIC.**—In discussing an article in the *Medical Age* (September), on the "Therapeutic Value of Music," Dr. Wm. E. Leonard calls attention to the following medicines:

*Digitalis*.—Fearful apprehensiveness, of a sad character, with great depression, extremely aggravated by music.

Intolerance of music: Ambra, chamomilla, sabadilla (especially instrumental), natrum carbonicum, nux vomica, phosphorus, sepia.

Aversion to music: Sabina.

Extreme sensitiveness to music: Aconite, causticum, mercurius, natrum sulphuric, viola odorata.

*Palladium*.—The right-sided ovarian pain and soreness is aggravated by music.—*Medical Current*, March.

**REMEDIES FOR LOCOMOTOR ATAXIA.**—Dr. Samuel Lilienthal, in the April *California Homœopath*, presents some remedies of value in the treatment of locomotor ataxia.

*Alumina*.—(Dunham preferred aluminum). Inability to walk, except with the eyes fixed on the feet in open daylight, so that he can watch their movements. Quiet and resigned disposition. Has a sensation as if he would fall forwards, which he greatly fears; not from dizziness, for his mind is clear, but from the consciousness of the unsteadiness of his lower extremities. Absence of the knee-jerk and other spinal reflexes; numbness of the heel on stepping upon the foot; great and tremulous lassitude of the body, especially after walking.

*Argentum Nitricum*.—Paralysis from exhausted nerve force; lassitude of lower limbs; he does not know whereon he steps; paresis of bladder; he passes urine unconsciously and uninterruptedly; tendon reflexes diminished or absent; idiopathic atrophy of optic nerves; gastric crises, with violent belching, which relieves; want of sexual desire; time passes slowly; aggravation from sweets; emaciation.

*Belladonna* (atropine).—First stage of tabes dorsalis; loss of co-ordination in the muscles of the upper and lower extremities; he raises his feet slowly and puts them down with force; cannot tell when the hands hold an object; when walking he raises the legs as if he had to pass an obstacle.

*Duboisin*.—Almost impossible to stand alone with eyes shut; sensation as if legs were unable to hold up body; staggering from one side to another when walking, but can go straight forward by watching his steps; tired feeling in limbs; paralysis of accommodation.

*Onium*.—Bad effects from suppressed sexual desire, or from excessive indulgence; trembling; painless lameness; powerless sensation extending all over the body; reeling when standing, and dragging his legs after him; papular eruptions, itching and burning.

*Gelsemium*.—Fresh cases: strabismus; ptosis; sexual weakness; irritability of seminal vesicles; genitals cold and relaxed; paralysis of bladder, with dribbling of urine; weakness in back and limbs, with sleepiness; loss of power in upper and lower extremities; staggering gait; numbness and lack of sensibility in extremities.

*Graphites*.—*Tabes dorsalis*, especially in women, with great weakness in legs and back; weakness and heaviness in extremities; they fall asleep; jerking of muscles; numbness or torpor of genital organs; herpetic constitution.

*Helleborus*.—Muscles do not act properly if the will is not strongly fixed upon their action; unsteady, feet weak, knees tottering; numbness of arms, with pricking and coldness.

*Kali Bromatum*.—Inability to stand or walk; handwriting shaky and indistinct: limbs shake and bend under him.

*Natrum Muriaticum*.—Constipation; involuntary urination when walking; pruritus genitalium; jerking sensation in back and nape, extending toward head; backache, with general weariness, worse lying down; paralytic condition of lower extremities.

*Nux Vomica*.—Paralysis of bladder, with dribbling of urine; constipation from irregular spasmodic action of intestines; constriction and stiffness in back; spinal irritation, with loss of power in extremities; unsteadiness of gait, with dread of falling; sensation impaired; legs cold and livid.

*Phosphorus*.—Ataxia and adynamia; weakness of mind and body, especially in the morning, as if had not had slept enough; numbness of whole body, with pricking sensations and anxious oppression; muscular asthenopia; scoliosis; tuberculosis.

*Physostigma*.—On walking feeling of unsteadiness; he must keep his eyes on his feet so that he can see where his feet are; muscular tremors and lightning-like pains in extremities, followed by diminished reflexes and paralysis; blurred vision; languor and flatulency; tetanic symptoms during first stage.

*Plumbum*.—Advanced cases of tabes or rather of disseminated sclerosis; sclerosis from hypertrophy of the connective tissue (silica), especially in the root zones, in the optic and third nerve; paroxysmal, lancinating, neuralgic pains, worse at night; total loss of co-ordination; formication; anaesthesia and paralysis with atrophy in limbs, with fatty degeneration; pains, better from pressure, worse from the least touch. Though praised for locomotor ataxia, the symptoms correspond more to other spinal troubles.

*Rhus Toxicodendron*.—Rheumatic palsy; loss of power of co-ordination in lower extremities, staggers, steps higher than usual; soreness in every muscle with jerking, tearing pains in them; walking difficult, slow and shuffling.

*Secale*.—Anxiety, sadness, depression; gentle creeping sensation in back, as if soft air was blowing through it; painful jerking of limbs at night; lassitude, heaviness and trembling of limbs at night; shuffling gait; fulgurant pains, absence of knee jerk; ataxy; aversion to heat and to being covered.

*Stramonium*.—Vertigo when walking in the dark, can only walk in the light; totters as if giddy; strabismus; muscles will not obey the will; limbs feel as if gone to sleep. Early stages.

*Zincum*.—Cerebro-spinal exhaustion; great weakness of all the limbs, especially in lumbar region and bends of knees; burning along the spine; pains in last dorsal vertebrae; impotence.

*PASSIFLORA*.—*Passiflora* seems to be especially adapted to derangements of the nervous system, as neuralgia, tetanus, chorea, insomnia. For the nervous, restless, excited or wakeful condition found in so many affections, it has a wonderfully soothing effect. Many of its symptoms are similar to those of cactus.—*California Homoeopath*, April.

*PICRIC ACID IN SATYRIASIS*.—Dr. E. H. Grahn reports the cure of a young married man who was "rather too amorous for any use," and whose sexual desire was getting the best of him. Picric acid 3x and ultimately the 6th reduced the erections to comfortable limits. The medicine also proved serviceable in a relapse in the same young man.—*American Homoeopathist*, April.

*SEPIA IN CHRONIC ENLARGEMENT OF THE TONSILS*.—Dr. W. F. Kærcher reports, in the *May Journal of Homoeopathica*, the cure of two cases of chronically enlarged tonsils, the excision of which had been advised by previously attending physicians, with *sepia* 30 and c. m. A number of *sepia* symptoms were present, the most prominent being enuresis during the first sleep.

*REMEDIES FOR CHOLERA INFANTUM*.—In the *May Medical Advance* we find an article from the pen of Dr. Ad. Lippe, deceased, on "*Cholera Infantum*," from which we summarize the following indications for remedies in the order of their importance:

*Apis*.—Child inclined to stupor, out of which it starts with a loud, shrill scream. The eyes have a reddish tint. The head is hot. The tongue is dry, but thirst is seldom present. The skin is dry, the hands at times cold and blue. Suppression of urine. The abdomen is tender to pressure. The diarrhoea is worse in the morning, always mixed with mucus, sometimes very offensive or involuntary, or containing flakes of pus.

*Belladonna*.—Child lies in a stupor; it frequently starts up suddenly in its sleep; when awake it is angry and violent. The head is hot, and is often rolled from side to side. The face is generally purple, red and hot, or very pale and cold. The tongue is red on the edges, or coated whitish-yellow, or has two white strips of coating, extending down on both sides of the tongue. Thirst moderate. Pulse very frequent, small and hard; occasionally full. Hands and feet cold; the hotter the head is, the colder are the feet. The abdomen is hot. The stools are clay colored or green, or consist of white or granular yellow slimy mucus, and are very frequent.

*Chamomilla*.—Child exceedingly peevish. The gums are very hot. The cheeks are red, at times only one cheek. The child wants to be carried all the time. Has attacks of colic; draws its knees up, and seems to be relieved for a short time after a passage from the bowels. Vomiting of food and sour mucus. The stools are green, or green mucus at times mixed with white mucus, or chopped; the discharges are hot, excoriating the parts; frequent, sometimes smelling like rotten eggs.

*Croton Tiglium*.—Child has a stool as often as it is fed or nurses. The discharge is sudden, noisy and violent, consisting generally of yellow water.

*Ipecacuanha*.—Diarrhoea and vomiting. Vomiting of food and drink as often as one drinks, or vomiting of green mucus. Much nausea, with pale face and oppressed breathing. Stools are of green mucus, or are bloody or fermented.

*Natrum Sulphuricum*.—Frequent attacks of violent colic, with rumbling in the abdomen, relieved by the violent discharge of yellow water with large quantities of flatus. The stools are more frequent during the morning hours, after the child is taken up and moved about, like bryonia.

*Podophyllum*.—Drowsiness or restless sleep, with grinding of the teeth or rolling of the head. Vomiting of frothy mucus, green, or of food. The diarrhoea is worse in the morning, and the discharges are more frequent at night than during the day. Stools green, watery, or mixed with mucus, or like chalk; profuse and painless. During and after stool, prolapsus ani. During dentition. Also catarrhal cough and catarrh of the chest. Cramps of the feet, calves and thighs.

*Sulphur*.—Disease generally begins after midnight. Diarrhoea and vomiting; the discharges from the bowels are generally watery, green and involuntary; they sometimes smell sour, at other times they are very offensive. Vomiting is frequent, often smelling sour (like calcaria), with cold perspiration on the face (veratrum, cold perspiration on the forehead). The face is pale, fontanelles open, hands and feet cold the very first morning. The child lies in a stupor, with its eyes half open. Not much thirst and entire suppression of urine. The child does not scream out violently as under *apis* or roll its head as under *belladonna*.

*Aconite*.—At the beginning of the disease, especially when it has been caused by a check of perspiration, mostly during the night, when the weather has changed from extreme heat to cold. Child excessively agitated and restless; pulse very frequent and hard; abdomen very hot; much thirst; the discharges are watery and contain bloody mucus.

*Arsenicum*.—Diarrhoea and vomiting; much thirst for cold water, but everything the child drinks is thrown up at once; hot skin; great restlessness; the child continuously tosses about, changes its position and cries incessantly; stools watery and very offensive, of black fluid, or dark thick green mucus; very great weakness and emaciation.

*Benzoic Acid*.—If during the attack the urinary discharges become very scanty; urine has a very pungent, strong smell; urine easily becomes turbid.

*Bismuth*.—Diarrhoea and vomiting; the vomiting prevails; all food and drink is thrown up at once; the abdomen is bloated; the face is pale; blue rings under the eyes (compare kreosote).

*Bryonia*.—The attacks return as the weather becomes hot, and are relieved on cool days (*aconite* and *dulcamara* have the reverse); vomiting of bile; tongue coated yellow; thirst, not frequent, but drinking of large quantities (*aconite* has the reverse); abdomen hot, the child does not want to be moved (*aconite* has the reverse; every motion causes pain in the abdomen and a discharge from the bowels, worse in the morning when beginning to be moved).

*Calcareæ*.—Open fontanelles; stools gray, like clay, smelling sour; vomiting of food, especially sour; profuse perspiration on the head during sleep; swollen, distended abdomen (*saccharum officinale*); urine clear (turbid urine, benzoic acid), is passed with difficulty, and has a strong, pungent, fetid odor.

*Carbo Vegetabilis*.—Diarrhœa; stools very putrid or bloody; face pale or greenish; the gums recede from the teeth and bleed easily; abdomen distended; emission of large quantities of flatus; skin cold; tongue and breath cold; voice hoarse or lost.

*China*.—Painless watery diarrhœa, yellow or blackish, or of undigested food; worse after eating (diarrhœa while eating, *ferrum*), and worse at night and after eating fruit, with much tendency to perspire.

*Colocynthis*.—Diarrhœa, with violent colic before, during, and after the stool, compelling the child to bend double, which seems to give relief (the colic of *belladonna* is relieved by hard pressure across the abdomen, that of *rhus toxicodendron* by lying upon the abdomen).

*Kreosote*.—Diarrhœa, with vomiting; the continuous vomiting and straining to vomit predominates; the child resists the tightening of anything around the abdomen, which increases the restlessness and pain; much thirst; gums hot; coldness of the hands and feet.

*Iris Versicolor*.—Diarrhœa and vomiting; vomiting of food, bile, or of a very sour fluid; profuse, frequent, watery stools; tympanites.

*Natrum Muriacum*.—Watery diarrhœa, with colic; incessant thirst with nausea; emaciation beginning at or principally on the neck; abdomen bloated.

*Nitric Acid*.—Diarrhœa, green, mucous or bloody, or putrid; putrid smell from the mouth; copious flow of saliva; ulcers in the mouth and on the tongue.

*Paulinia Sorbilis*.—Green profuse stools, *inodorous*.

*Petroleum*.—Diarrhœa only during the day.

*Phosphorus*.—Diarrhœa and vomiting; desire for cold water, which is thrown up as soon as it becomes warm in the stomach; diarrhœa is worse in the morning; stools consist of green mucus, brown fluid, white mucus, or containing little grains like tallow.

*Silica*.—Fontanelles open; much perspiration on the head; great thirst; emaciation; rolling of the head; suppressed urinary secretions; watery, very offensive stools (*calcareæ* has sour-smelling stools).

*Sulphuric Acid*.—Frequent, large, watery, very offensive evacuations, with aphthæ and great irritability.

*Veratrum Album*.—Diarrhœa and vomiting; great weakness; vomiting of frothy substance; profuse watery diarrhœa with flakes; during stool cold perspiration on the forehead; pale face; cold hands; voice weak or hoarse; suppression of urine.

**ALOES IN INFANTILE DIARRHœA.**—Dr. H. Cuvier Jones, in the *May Clinical Reporter*, reports the following case: "Was called to see Maggie B., aged one month, who was thought to be dying. Found her very pale, pulse weak and accelerated, but regular. Learned that she had had diarrhœa for two or three days, but discharges had not been frequent, nor of bad character; that she had had a large yellowish stool and sank away until the family thought her dead immediately following it. Gave *aloes* 3x, in water, every two hours, and she recovered rapidly and without other medicine."

**HYDROCYANIC ACID IN DIARRHœA**—Dr. A. Cuvier Jones reports two severe diarrhœas cured with *hydrocyanic acid* 4x.—*Clinical Reporter*, May.

**REMEDIES FOR DIARRHœA.**—Dr. George Wigg, in the *April California Homœopath*, gives indications for the following remedies in diarrhœa:

*Graphites*.—Pappy, half-digested brown stools of a most atrocious odor.

*Iris Versicolor*.—Stools tinged with bile in a continuous stream; green, undigested, mushy, pappy, bloody mucus; straining, burning in anus and rectum after stool; black, with fever; hot sweat; white tongue.

*Jalap*.—Stools very dark, very offensive, and of gruelly consistence; much griping and some tenesmus.

*Sulphur*.—Diarrhœa caused by drinking beer; in the morning, with red line around the anus.

*Oralic Acid*.—Frequent ineffectual urging to stool, preceded by a sick distressed feeling from the navel downwards; worse when thinking about it, and from drinking coffee; sugar aggravates pain in the stomach and wine causes headache.

*Oleander*.—Evacuations of scanty, thin, watery stools, with burning in the anus before and after stool.

*Allium Cepa*.—Diarrhoea after midnight or toward morning; offensive flatus; fissures in anus.

**ARSENICUM ALBUM IN CHRONIC DIARRHOEA.**—"Mrs. B., aged 40, consulted me November 18, 1889. Has had diarrhoea since January, 1888. Discharges were at first fecal, then yellowish mucus, and, after about two weeks, bloody. Always offensive, scant, frequent with burning, urging pains. Prolapse of bowel whenever stools became frequent, at times necessitating replacing with the fingers. Frequent, scanty micturition, at times considerable burning. Has had constant, persistent thirst during entire illness. Diarrhoeic attacks always come after midnight, usually from 1 to 2 o'clock A. M. Cannot use potatoes or other vegetables, or any food containing vinegar. Has had three violent attacks of cholera morbus since bowel trouble began. Of late, considerable palpitation, irregular and violent breathing of the heart. Prescription, *arsenicum album* 30, on globules, three times a day. Returned February 12th, said she had thought herself cured, but there was slight recurrence of trouble. Received the same remedy as before, and, April 12th, said: 'I am cured. Can eat anything I want. Feel well, and my bowels are regular and normal in action.'"—Dr. A. Cuvier Jones, *Clinical Reporter*, May.

**ALOE IN DYSENTERY.**—"Was called to see Mr. H. at 8 o'clock A. M. He had been ill since before midnight. Awoke feeling that his bowels must move; arose and started for the closet, when he fainted and fell to the floor. The bowels moved several times before morning. When I saw him the stools were of blood and mucus, not offensive, attended with great urging and griping before the movement, and followed by such weakness and prostration that patient must fall over in the bed as soon as he attempted to arise from the vessel. Gave him *aloes* 3x dilution, in water, teaspoonful after each defecation. He was at his place of business the second day, yet he was subject to attacks of dysentery, and when attacked similarly six months before, and treated allopathically, kept his room for three weeks and came near dying."—Dr. A. Cuvier Jones, *Clinical Reporter*, May.

**ARSENICUM ALBUM IN DYSENTERY.**—Dr. A. Cuvier Jones cured T. L., of a severe dysentery over-night with one dose of arsenicum album 6th trituration.—*Clinical Reporter*, May.

**RUMEX CRISPIUS.**—"Children with the rumex cough will become extremely cross and peevish, precisely similar to that condition which obtains under chamomilla. This may lead, by mistake, to the giving of the latter drug, when, in fact, rumex ought to have been exhibited, which would be followed by a speedy cure. Belonging to this valuable drug there is a condition which closely corresponds to lycopodium, viz: After meals, great flatulency and distension of stomach. Sensation of fulness after eating, with pressure so great that it extends up into the throat. Another peculiar condition which was evolved in the proving of rumex is one that is evidently connected with digestion, and which does not, to my knowledge at least, belong so prominently to any other drug. I allude to the lump in throat, not relieved by hawking or swallowing; it descends on deglutition, but immediately returns. I have cured many so-called cases of dyspepsia with this remedy, in various potencies, where the above characteristic was a prominent factor."—Dr. C. Carleton Smith, *Homœopathic Physician*, June.

**BRITISH MEDICINAL PLANTS.**—We summarize from an article written by Dr. Alfred Heath, under the above caption, the following:

*Clematis Vitalba*.—Is very acrid, its leaves producing a warmth on the tongue, and if chewed for a short time, causing blisters. They also blister and ulcerate the skin when rubbed into it. It has been used internally as a cure for the lues venerea, certain forms of scrofula, and rheumatism.

*Clematis Erecta*.—It has produced swelling of the testes and scrotum, with painful sensitiveness, violent pains in the left spermatic cord (in women it has cured glandular induration of breasts, painful to touch); rheumatic-like pains, aching, drawing, tearing in limbs, and a great number of symptoms affecting all parts of the body.

*Anemone Pulsatilla*.—This plant, although very much like the *pulsatilla nigricans* of the homœopathic pharmacopœia, is not the same, and should never be used for it.

It has been used with considerable success in diseases of women, headaches depending on functional derangements, inflammation of the eyes and eyelids, and malignant ulcers. It is useful in discharges from ears, nose, eyes, etc. It is very acrid, and not yet "proven."

*Anemone Nemorosa* (the ranunculus albus of the pharmacopœias). The acrid, volatile principle is so corrosive that it has been used externally as a blister, instead of cantharides. It was used empirically in times past to promote the menstrual flow and for the cure of leprosy. The juice was snuffed up the nose to promote discharges, and the root was chewed to cause expectoration, on account of its acrid properties. It was found useful in headaches, in soreness and inflammation of the eyes and lids.

*Pulsatilla Nigricans* (anemone prætensis).—Baron Stœrck recommended it as an efficient remedy for most of the chronic diseases affecting the eye, particularly amaurosis, cataract and opacity of the cornea. He also found it of great service in the nodes and nocturnal pains of syphilis, and in ulcers, caries, indurated glands, suppressed menses, herpetic eruptions, melancholy and palsy. When chewed it inflames the tongue and fauces. It produces in the healthy various kinds of inflammations of the eyes and eyelids, with pain and swelling; lachrymation in the open air, dimness of sight, obscuration of sight, and a great many other eye symptoms; powerful and varied action on the sexual and urinary organs; eruptions on various parts of the body, which burn, itch and bleed; uterine spasms, suppression of the menses, great melancholy and depression of spirits, sadness, silent mood, weeping, motor disturbances, painful lameness, debility, rigid immobility of body, tingling and sensation as if limbs had gone to sleep, tremulous weakness, trembling of the hands and of limbs generally.—*Homœopathic Physician*, June.

A FRAGMENTARY PROVING OF *PODOPHYLLUM*.—Dr. E. V. Ross, in the June British *Homœopathic World*, gives the following: Mr. E. J., aged 26, at 10 A.M. took ten grains of podophyllum 1x to "stir up his liver." At about 6 P.M. of the same day was taken with an indescribable sick feeling all over, and a *persistent dry-rough feeling in pharynx and œsophagus*, and a *feeling as though a ball or lump was in the upper part of the œsophagus*. This dry rough feeling extended along the right Eustachian tube, with dull aching pain in the right ear. 8 P.M.—Dull stupefying headache, chiefly in forehead and by lying down. Fulness in region of stomach, with belching of gas, and sour eructations. Marked salivation and offensive odor from the mouth; sleep disturbed and full of confused dreams; rolled about, *bed felt too hard*, and a *feeling as though the head and shoulders were lying too low*. At 3 A.M. was hurried to stool, which was profuse, watery, and dark-green in character; frequent call for stool, with a peculiar, weak, dull, gripping pain below umbilicus, and fulness in the rectum before and after stool; faint, weak feeling in region of stomach during stool; tenesmus and faint feeling after stool. These symptoms gradually passed off in the course of two or three days.

*CALENDULA OFFICINALIS* IN DEAFNESS.—"In January a lady asked me to prescribe for a page-boy, aged 14, who had suffered from deafness from infancy. There was a history of otorrhea in childhood, but the tympanal membranes were fairly smooth and without signs of previous ulceration; slight adenoid tumefaction in the post-nasal region. Patient states he is sometimes worse than at others, and particularly so in damp weather; talks thickly; general health good. Watch-hearing, R. 30, L. 20. After taking calendula for a night his watch-hearing went up to 60 in. on R. and 50 in. on L. All remarked how much better he was. That the effect was due to *calendula* is perfectly evident, for his hearing has since then gone back on leaving it off. I have not the least doubt from what I know of *calendula* that it will complete the cure."—Dr. E. T. Cooper, British *Monthly Homœopathic Review*, June.

*MELILOTUS* IN MANIA.—"A lady imagined herself mesmerized by her absent pastor, and was in a great fright. Aconite 1000 quieted her, but did not remove the delusion which soon mingled with others—that every one was possessed of the devil, that her eyes were strangely wild, and that nothing was as it should be. Her face was very red, but there was no headache or other ascertainable symptom. Melilotus 30 was given in water, for two days, with most happy effect. Improvement was rapid, the illusions faded and a state of delightfully restful sleepiness came on. She quitted the bed in less than a week, and her fancies have not returned."—Dr. Edward Cranch, *Homœopathic Physician*, June.

# THE HAHNEMANNIAN MONTHLY.

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## TACHYCARDIA VASO-MOTORIA.

BY EDWIN M. HALE, M.D.

(Read before the Illinois State Homœopathic Medical Society, Chicago, May 21, 1890.)

UNDER this new name I propose to give the etiology and treatment of that mysterious disease known as "Basedow's Disease," "Graves's Disease," and "Exophthalmic Goitre." This disease has not yet had a specific name, or one suited to its real character and cause. Nor is *Tachycardia* a name that fills all the requirements, for it means only a "rapidly beating heart," but it is a better name than any heretofore given.

This disease, in its complete form of the symptomatic triad, namely: "palpitation with throbbing of the arteries of the neck, vascular turgescence and enlargement of the thyroid body, and prominence of the eyeballs," was first described by Graves in 1835. But this triad is not always complete, as has been witnessed by many observers. I have seen many cases, which were true examples of this malady, where the protrusion of the eyeballs was not present, while the enlargement of the thyroid was, and other cases where neither the thyroid nor the eyeballs were affected.

The fact is, that this disease is not a disease of the heart, but of the vaso-motor centres in the brain, or of the ganglia in the sympathetic. Graves supposed it was a "cardiac neurosis," *i.e.*, having its seat in the cardiac ganglia. Niemeyer attributes this affection to a "palsy of the vaso-motor nerves." Trousseau thinks it a "neurosis of the sympathetic from congestion or structural change of the ganglionic system." Brunton is of the opinion that the disease is due

to "direct stimulation of the accelerator nerves of the heart which descend from the vaso-motor centre in the medulla oblongata in company with the vertebral artery, and after passing through the inferior cervical ganglion of the sympathetic are supplied to the heart." He explains that the protrusion of the eyeballs, the enlargement of the thyroid, and the vascularity and degeneration of the sympathetic ganglia are from the same cause. Hayden believes that this "singular combination of symptoms depends on vaso-motor paresis." My observations have convinced me that Hayden's opinion, added to that of Brunton, is correct. But I believe that in many cases alternate and opposite states of the vaso-motor nerves occur,—at one time paresis, and at other times irritation.

"The questions of the *pathology* and the morbid anatomy of this disease," says Dr. Hammond, "have always been enigmas, and have not to this day been positively and satisfactorily settled, though probably the solution of the problems is not far distant." A year or two ago it was almost universally believed that certain lesions discovered in the cervical sympathetic were responsible for the symptoms. At this date there are many and potent reasons for believing that, in the majority of cases at least, the sympathetic system is not involved at all, or, if it is, it is involved secondarily, and that the lesion is of an irritative nature and is situated in the medulla oblongata. It may possibly not be long before the origin of the disease can be traced to even a higher level,—that is, to the cortex,—for it is well known that mental shocks, such as fear, which unquestionably affect the cortex, have resulted in exophthalmic goitre, just as they have in epilepsy, in chorea, and many other forms of nervous diseases. At the present time, however, it is only necessary to consider the two theories which can be supported by any evidence which is in the least degree conclusive. These theories are: 1. That exophthalmic goitre is due to disease of the cervical sympathetic system. 2. That it is due to an abnormal condition of the medulla oblongata.

In regard to the first theory, the evidence goes to show that in many cases *post-mortem* examination discloses disease of the sympathetic nerve, and particularly of the cervical ganglia. The changes observed in the ganglia are enlargement, hardness and redness, granular degeneration, infiltration with round cells or with spindle-shaped cells, destruction of the ganglionic structure with increase in the amount of connective tissue. Physiological experiments on the sympathetic nerve also prove conclusively that the symptoms of exophthalmic goitre can be produced artificially by this means.



The arguments against this theory are certainly very convincing. A number of cases are recorded where no change can be discovered in either the sympathetic nerve or its ganglia. Hammer, in a report of a case of his own, where no lesion of the sympathetic could be discovered, cites twenty-two other cases where autopsies were obtained. Of these, seven showed lesions in the sympathetic system, while in the fifteen remaining no sympathetic lesion could be discovered at all. Two other autopsies have been reported since then, in neither of which were the sympathetic nerves diseased. As to the physiological experiments, though it is admitted that many of the individual symptoms, such as dilatation of bloodvessels, exophthalmia, enlargement of the thyroid gland, contraction of the lids, and accelerated action of the heart, can readily be obtained by producing artificial lesions of the sympathetic, it is well known that any one such lesion cannot result in all of these symptoms, since some of them are produced by paralysis and others by irritation of the sympathetic. I think it will be admitted that it is clearly impossible for any one lesion to produce both irritation and paralysis at the same time. The theory of a central lesion is far more acceptable to my mind. In the first place, centres are known to exist grouped together within a small area in the medulla, lesions of which result in the appearance of the three principal symptoms of the disease.

Filehne, in his well-known experiments, produced each of the three symptoms in turn, and, in one case, all three of them together, a result which has never been attained by any single lesion made on the sympathetic. Probably the fourth symptom—Dr. Bryson's symptom—was obtained also by Filehne, although, not knowing of its existence, he probably did not look for it. In the second place, it does not seem unreasonable to attribute the three principal conditions of vagus paralysis, vaso-motor paralysis and respiratory paralysis, which produce the four principal symptoms, accelerated heart action, enlargement of the thyroid gland, exophthalmia and diminished chest expansion, to a single circumscribed lesion affecting the vagus nucleus, the vaso-motor nucleus and the respiratory nucleus. Polyuria, which is a frequent symptom of Graves's disease, can also be produced by a lesion in this region. Physiological research is not unsupported by *post-mortem* evidence. Dr. W. Hale White, *Brit. Med. Journal*, March 30, 1889, has reported a case where "the sympathetic was found to be healthy. A series of sections were made from the lowest part of the medulla to the corpora quadrigemina. At the level of the lowest part of the olivary nucleus there was, just

under the posterior surface of the medulla, evidence of slight inflammation. The next few sections were quite healthy, but those in the neighborhood of the sixth nerve showed considerable changes. Immediately under the posterior surface of the medulla, extending from the mesial line as far out as the restiform bodies, which were slightly implicated, were numerous hæmorrhages. The area occupied by these hæmorrhages did not extend deeply, so that, except for a slight implication of the nerve cells of the sixth nucleus on one side, the nerve cells had escaped injury. The hæmorrhages seemed almost entirely limited to the posterior part of the *formatio reticularis*, but there were two or three small, deep ones. They were not marked at this level, but were observed up to the lower part of the aqueduct of Sylvius." Dr. White believes this is the first case where organic lesions have been discovered in the medulla in exophthalmic goitre, but Lockhart Clark reports a case where the "*corpora quadrigemina* and the medulla, particularly on its posterior part, were very soft, and, on minute examination, displayed the usual appearance of common softening."

There is a strong probability that there is a general dilatation of the bloodvessels. It has been conclusively shown that in exophthalmic goitre the electrical resistance of the patient is very much diminished below the normal point. And although, as yet, there is no absolute proof, it seems plausible and probable that a general dilated condition of the vessels would account for the greatly diminished electrical resistance. In many instances no lesion has been discovered at all, and the burden of proof goes to show that exophthalmic goitre is frequently a reflex neurosis. It is not essential that even the fatal cases should be of organic origin, as a reflex irritation can readily be imagined to be of so powerful a nature as to produce almost total degeneration of the nerve cells in the medulla, which, of course, in the present state of our knowledge, would be undetected after death. The theory that exophthalmic goitre is often of reflex origin is supported by clinical evidence. Semon reports a case on which he operated by means of the galvano-caustic loop for the removal of multiple recurrent mucous polypi of the nose. Within a day or two after the operation, exophthalmia of the right eye suddenly appeared. Græfe's and Stellwag's symptoms were both present, but there was no enlargement of the thyroid gland and no increased action of the heart. Hoffman, of Cologne, reports a case of exophthalmic goitre which was entirely cured by an operation performed within the nasal cavity; and Hack, of Freiberg, and B. Fränkel, of

Berlin, both report cases where operations for nasal diseases have cured cases of Graves's disease. It will not be amiss to mention here that Mr. George Storker, of London, reports two cases where ordinary goitre disappeared after intra-nasal operations. It will be observed that in all of these cases the reflex disturbance was situated within the nasal cavity. The thought will at once occur to us all that if nasal irritation can reflexly result in exophthalmic goitre, irritation in other parts of the body can do the same. It would be well, therefore, in the future examination of patients, to search for and relieve such abnormal conditions as we know are most likely to result in reflex neuroses. These abnormal conditions are most likely to be found in the eyes, the nasal cavity, and the genito-urinary apparatus." (Reflex irritations from the rectum have been known to cause it.)

The deduction from the above is this,—that to cause all *four* of the essential symptoms of this disease united in the same subject, it may be necessary that the lesion shall be in the *cortex*,—that in those cases in which we find only one (tachycardia) or two tachycardia and swelling of the thyroid, or any other combination not including all *four*, the lesion or lesions may be confined to the sympathetic, or one centre in the medulla.

Dr. Hammond, in the *New York Medical Journal*, January 25, 1890, mentions a new diagnostic symptom. He says: "The usual three cardinal symptoms, upon the existence of one or more of which the diagnosis depends, are so well known as to need no comment. The various other symptoms, which are as often absent as they are present, are so familiar to you all that any further mention of them is superfluous; but there is one symptom which has recently been discovered which deserves considerable attention. I refer to Dr. Louise Bryson's symptom. It has never been observed before as far as I can ascertain, and is of the greatest importance in regard to the prognosis of the disease, and is also of assistance in locating the seat of lesion. Dr. Bryson's symptom consists in the *inability of the patient to expand the chest under forced inspiration up to the normal extent*. In every case that has been examined since Dr. Bryson's discovery, this deficiency has been observed. In some instances the loss of the power of expansion is remarkable, and Dr. Bryson states that where the expansion is found to be reduced to half an inch or less, the termination of the case is invariably fatal.

"This statement has been sustained in at least one case that I know of. In five cases that came under the care of my assistant, Dr.

Combes, and in three cases that came under my personal inspection, this symptom was observed; and in all of the cases, as recovery gradually took place, the power of the chest expansion has been slowly restored."

I have a patient who has suffered from this disease for three years (the protrusion of the eyeball is not present), whose chest expansion is only three-quarters of an inch.

Dr. E. C. Williams reports a typical case of a year's duration whose chest expansion was only one-half inch, but under spigelia it has increased to one and a quarter inches.

This symptom should be observed hereafter in every case, and its improvement under remedies noted carefully by measurement.

The *causes* are mental emotion of any sudden intense nature; mental worry long continued; a fright or mental shock; prolonged watching and anxiety. In fact, most authorities agree that nearly all cases originate from the mental sphere. In a few cases the cause was supposed to be violent physical exertion. I can recall but few cases out of the many I have seen that had other than mental or emotional causes, so far as I was able to trace their history. The pulsations of the heart and the radial and other arteries are generally rapid, full and strong, reaching sometimes as high as 160 per minute. But I have seen this condition change in a day to a condition in which the pulsations of the heart and arteries were irregular, intermittent and feeble, and continue so for weeks or months; then suddenly reverting to the former condition. All this points to an alternating vaso-motor neurosis. The mental states of the patients are peculiarly changed. A person previously of mild and amiable temperament will become irritable, peevish, impatient and exacting, and alternately excited and depressed, or joyous and melancholy by turns. In many cases a hysterical condition is clearly present. The temperature is generally elevated, but I have known cases in which it was subnormal. Morbid appetite and anorexia alternate. The menses are sometimes profuse; at other times scanty. There may be diarrhoea or constipation, both very obstinate.

The *treatment* of this disease has had a most varied history according to the diverse and various theories as to its cause. Those who believed that anæmia was the cause, relied on the use of iron; others gave digitalis, believing it was a local cardiac neurosis. Iodide of potash had its friends. Electricity and galvanism were used to combat the supposed paralysis of the sympathetic. Iodine has been used for the goitre, but never with decidedly good effects. Belladonna has

been given with good results by the dominant school for its supposed antipathic action, while it was really homœopathic. But only a few real cures have been made with these agents. Our own school has not been much more successful because the supposed homœopathicity of the remedies selected was only apparent, not real. There are, according to my studies and observations, only three real homœopathic remedies for this strange disorder. They are *aurum*, *glonoine* and *spigelia*. *Belladonna* may be added to the list, but it does not cover all the symptoms.

*Aurum* has the arterial and cardiac excitement, but lacks some of the local symptoms.

The *bromide of gold* has been used in typical cases of Basedow's disease by some French physicians with alleged success. In two cases I saw marked improvement from the 2x trituration in 2-grain doses ( $\frac{1}{80}$  grain) three times a day. It relieved the cerebral throbbing, the mental irritability, melancholia, and the cardiac excitement.

*Glonoine* has the vaso-motor paralysis to a great degree. It has the sensation and, even to some extent, the real protrusion of the eyeballs. No remedy yet found has the swelling of the thyroid in connection with the tachycardia. In fact, no known drug ever caused a swelling of the thyroid or anything like a goitre.

*Glonoine* has done good work for me when the throbbing and congestion of the head resulted in positive pain. Here the third dilution was used. It has also been of great value in those cases where sudden cardiac syncope threatened; the heart's action becomes very feeble and irregular, pulse scarcely felt, and the patients thought they were dying. But the proper dose in such cases is the  $\frac{1}{80}$  or  $\frac{1}{160}$  grain (1 or 2 drops of the 1c).

The experiments on animals with *spigelia*, recorded in the last edition of my *Diseases of the Heart*, present a perfect and graphic picture of Basedow's disease, including, as the violent action of the heart, its great rapidity of action, the great protrusion of the eyeballs, and many other symptoms. The provings also show in a marked degree its close homœopathicity. Yet it has been but little used in this disease, and then only as a palliative. Since those experiments were made and published, I have not had a typical case calling for *spigelia*; therefore, I cannot give any personal experience with it. I would advise that it be used with caution as to dose, giving not lower than the 3x.

*A Case Illustrating the Curative Action of Spigelia, reported by E. C. Williams, M.D., of Chicago.*—"Miss A. came to me for treatment with the following history: In June, 1889, she commenced to be troubled with palpitation of the heart (for some months previous to this had not been in good health, she being a nurse, having to work very hard, with irregular hours). With the palpitation had come some acceleration of the pulse, but with no apparent abnormal heart symptoms. About two months later struma was developed, the enlargement in the course of a short time increasing the circumference of the neck about two and one-half inches. This, however, was subject to changes, varying in size. Almost immediately following this, exophthalmia developed, the left eye more prominent than the right. At the time of her coming to me she was greatly emaciated, suffering intensely with stabbing pains in and about the heart. There was an insufficiency of the mitral and aortic valves. The chest expansion was only three-quarters of an inch. The pulse was from 140 to 160 beats per minute; temperature about normal; sleep was disturbed; respiration was hurried, and at times carried great aggravation of the "stabbing" pains. There was great loss of muscular power; in fact, an almost total inability to help herself in any way. Several remedies were tried in rapid succession with no benefit whatever. At last she was put upon spigelia 2x, I being led in that direction by the chapter on spigelia in Dr. E. M. Hale's new edition of his work on the *Heart*. This drug was prescribed for two weeks, when I thought there was some general improvement. The pains about the heart were certainly relieved. She was then put upon spigelia 6x. In three weeks more there was a marked diminution in the swelling of the thyroid, the protrusion of the eyeballs was less marked, and the pulse-rate was down to 125. This remedy has been prescribed in from three to five times in twenty-four hours, and at the present time the pulse-rate is 80; temperature normal; the swelling at the thyroid has entirely disappeared; the exophthalmus is no longer present; the expansion of the chest is one and three-quarters inches, and the abnormal conditions of the heart are much improved. The lady has gained twenty-five pounds in weight. I am confident now that she will entirely recover."

If we feel we ought to use some preparation containing iodine, spongia is the best, for in its provings we find many symptoms which make it applicable to this disease. Of the newer remedies, I can give some personal experience.

*Lycopus* will often give great relief, but it is only indicated when, with some exophthalmus, the pulmonary symptoms are the most prominent. Cough, hæmoptysis and hectic fever, together with the rapid pulse of 140 or more, call especially for this drug. I do not usually give smaller doses than the 1x, and have often seen the best results from five-drop doses of the tincture, frequently repeated.

*Baryta muriatica* (chloride of barium) is a drug which ought to be beneficial in some cases of Graves's disease. Recent experiments show that small doses are capable of slowing the heart, and making its action fuller and stronger. Now we know that baryta has great influence over indurations and enlargements of glandular structures, and also to check abnormal development of connective tissue. It seems to me that it ought to be of service in this disease when occurring in the old or prematurely aged, when with a tendency to fatty degeneration and ætheroma, then occurs tachycardia with weak heart, and enlargement and induration of the thyroid. It also has the power of contracting the muscular tissues of arteries and veins, and must therefore act on the vaso-motor centres.

*Convallaria* differs from other cardiac sedatives in its greater power of quieting and calming the nervous system. In Graves's disease, as I have above stated, the mind and brain becomes very irritable, and the emotional sphere morbidly sensitive. Here, the lily of the valley has a very happy effect, calming the almost hysterical erethism as well as the tachycardia. The unpleasant general throbbing of all the arteries is lessened under its influence. The dose is 5 to 10 drops of the  $\theta$  or 1x three or four times a day. Always use the tincture of the flowers.

The following case reported by Dr. W. A. Smith, of Morgan Park, Ill., illustrates the action of *convallaria*:

"Mr. —, æt. 42, light complexion, presented himself for treatment in April, 1883, with the following symptoms: Rapid action of the heart, averaging 114 beats per minute the first month; eyes slightly protruding, and some enlargement of the thyroid gland. He complained of feeling tired, that he could stand no work or any excitement on account of his heart. Appetite capricious; could not sleep very well; had frontal headache, worse in afternoon. The stethoscope gave a rather peculiar sound that was anæmic in character. As he was a stranger to me, I did not take any particular notice of the eyes or gland, and the diagnosis of the disease was not given, but prescribed bell. 30x, four pellets every three hours. The only improvement was, that he rested better, and did not complain of his head. Then I gave iod., dig., ars. iod., and, after them, every remedy in whose symptomatology the word gland was used. After he had been under treatment about six months, and slowly losing ground, he became dissatisfied, and decided to go to Ohio and try his old family physician, and I bid him God-speed, glad to get him out of my care. He was away more than three months, when he returned with marked aggravation of all the symptoms. Pulse 130, eyeballs very prominent, and the right side of the gland nearly double the size it was when he left. He requested me to again as-

sume charge of the case, and not feeling competent to handle it any more satisfactorily than before, I went to Chicago and consulted with Dr. E. M. Hale. He suggested the use of convallaria tincture, five drops every four hours, for the heart, and under its use the action of that organ became nearer normal, and decreased to 100 beats per minute; but, do what I could or would, he was getting weaker, and when I would stop the convallaria the pulse would bound to 130 or more per minute. He had become almost a skeleton. The conclusion was, that he must be better nourished, and the heart's action be reduced; so I increased the convallaria to ten drops every five hours, and gave Reed & Carnrick's beef peptonoids. I never saw any one do better than he under this treatment; and inside of four months he was at work, and has been ever since.

"The patient died in 1889, of some liver trouble, but not being in attendance I cannot say if the old exophthalmic difficulty returned or not."

*Collinsonia* has rendered me good service in a few cases when hæmorrhoids complicated the case to an unpleasant degree. Hayden mentions a particularly bad case of Graves's disease brought on by painful bleeding piles.

*Oleander*, as you will see by the provings and recent pathological experiments, is a heart poison which accelerates and depresses the motor function of the heart. Its alkaloid, nerine or oleandrine, is as powerful as digitalin. I have never used it, but would suggest it in those cases attended with diarrhœa of undigested food, a condition sometimes observed in this disease.

Aconite has been used by both schools in Graves's disease, but I have never seen good results from it except when the pulse is small, tense and rapid, symptoms which are rare, but have sometimes been observed. Generally, vaso-motor paresis is present, but vaso-motor irritation, with great vascular tension, has been observed.

Dr. E. C. Sequin, *New York Medical Journal*, April 26, 1890, speaks highly of aconitine in some cases. In a recent lecture on this disease he says:

"The two new measures I wish to call your attention to are, first, the systematic employment of aconitine, and, second, bandaging of the protruding eyeballs. In 1884 I rather accidentally discovered that aconitine (the crystallized aconitine of Duquesnel) exerted a powerful reducing influence on nervous or irritative fast pulse, i.e., a fast pulse with high tension and normal heart, easily distinguished from the fast pulse of cardiac disease or general debility or fever.

"(Of course, it has long been known that aconite reduces the



pulse. I refer to a very decided effect upon a special sort of a pulse.)

"Aconitine in granules of  $\frac{1}{100}$  of a grain greatly reduces the pulse-rate and also the arterial tension. In Basedow's disease I give from three to eight pills a day for days and weeks, occasionally stopping for a few days. On the average, it is necessary to give two pills three times a day; under this the pulse-rate steadily falls from the upper limits of 160 or 140 a minute to below 100. After that the fall is slower, but in many cases goes on until 90, 80, and even 70 beats are recorded to the minute. At the same time the eyes and neck usually improve. This treatment occasionally fails, but it never does any harm. I have used it in quite a number of cases, some without goitre and exophthalmia, since 1884, and it has been tried with good results by several of my professional friends. At the same time iodide of potassium or iron may be given and galvanism applied in the usual way."

*Strophanthus* is certainly more efficacious in this disease than digitalis. Why this is so I cannot explain, because we have no extensive provings of it. I imagine, however, that its action is more upon the accelerator nerves and less upon the intercardiac ganglia. It has more influence on the thyroid than digitalis, and its sedative action is more lasting. Once the pulse becomes slower, it does not regain its quickness for many days after its use is suspended. In one case it cured the uterine hæmorrhages, which were rapidly reducing the patient. The dose varies from five to ten drops of the 1x to the same quantity of the tincture three or four times a day.

Dr. Hammond (*loc. cit.*), of New York, says: "Experiments by Fraser, Drasche, and Zerner and Loaw show that *strophanthus* prolongs the diastole of the heart, causes it to beat more slowly, and to discharge at each contraction a larger quantity of blood into the arterial system; at the same time the arteries become contracted. These facts are clearly expressed in an article in the *British Medical Journal*.

"Bakadhurji, who experimented with *strophanthus* in co-operation with Langgaard, of Berlin, found that *strophanthus* has a marked effect upon the vagus. They report also that the respirations are at first increased, but are subsequently slower and weakened. This may be the result on the healthy organism, but in exophthalmic goitre, at least in the cases that have come under my observation, the respiration becomes slower and stronger, while the power of expansion becomes greater. It is, therefore, probable that *strophanthus* affects the central respiratory centre as well as the vagus centre. If these statements are true, we have in *strophanthus* a remedy which would exert a powerful influence in subjugating the four principal symptoms of exophthalmic goitre, namely, the exophthalmia, the

enlargement of the thyroid, the cardiac rapidity, the shortened respirations, and the diminished chest expansion. Zerner and Loaw have employed strophanthus with success in this disease. Brower reports three very interesting cases which were cured by this drug in from four to six weeks. Three cases of my own show decided improvement under its use. Other observers have used it with advantage, but the foregoing cases are sufficient to show its practical utility in many instances. The only preparations of the drug which can be obtained are the tincture of strophanthus and strophanthine. The latter is hardly available for therapeutic purposes, as its extreme potency renders its use dangerous. The ordinary dose of strophanthine is  $\frac{1}{3000}$  of a grain."

Dr. Hammond, in the same article, says: "The other remedy which I wish to call your attention to is the carbazotate of ammonium. As a remedy for exophthalmic goitre, we are indebted for its discovery to my clinical assistant, Dr. A. C. Combes. He discovered it accidentally in the following way: A patient afflicted with exophthalmic goitre consulted him nearly a year ago. She had been under the care of a well-known New York physician, who, not recognizing the nature of her complaint, and thinking she was suffering from some febrile disease, gave her the carbazotate of ammonium. She was subsequently told the name of her disease, and, feeling dissatisfied with her physician, she left him and consulted Dr. Combes. Dr. Combes found that under the drug she was taking, her symptoms were disappearing. He continued the remedy with excellent results, and has since used it on five cases, and in all of them with benefit. I have used it on three cases of my own with, I think, decidedly good results. Its use is, however, limited, and for reasons which I will now mention cannot be given indefinitely. Following the direction of Dr. Combes, I have given the remedy in pill form (each pill containing one grain of the drug) three times a day for the first week. In the second week, two pills three times a day are given, and, if it can be borne, three pills three times a day in the third week. The physiological effects of the drug are very decided. They were observed by Dr. Combes, and his observations have been verified by my own. At about the end of the first week the skin and conjunctivæ assume a slight saffron color, which deepens if the drug is persisted in. Then a peculiarly unpleasant odor emanates from the body, which is identical with that produced by dirty feet, and can be distinctly noticed if you approach within six or eight feet of the patient. Following this, severe gastric disturbances show themselves.

"It is rarely possible that patients can take this remedy longer than three weeks, but while they take it the effects upon the heart, the respiratory tract, and the exophthalmia are undoubted."

This drug, called by Dr. Hammond "carbazotate of ammonium," is known to us under the name of "*picrate of ammonia*," in which *picric acid* is the real efficient agent. An examination of the prov-

ings and physiological experiments given in Allen's *Encyc. Mat. Med.*, shows that it causes many of the prominent symptoms of Basedow's disease, viz., the headache with throbbing in the cerebral arteries; pain and soreness in the eyeballs; great irritability of temper; sensation as if a band encircled the chest; palpitation of the heart, etc. But it is doubtful if the drug is really homœopathic to the state of the heart. In the cases where the heart was *slowed*, the doses were large (from  $\frac{1}{16}$  grain to 1 grain). In those cases the pulse fell from 70 and 75 to 55 and 50. This was a physiological or pathogenetic effect. The primary effect of picric acid may be vaso-motor paresis, with increased action of the heart, similarly to aurum, spigelia and glonoine; but the secondary effect may be the opposite, though we do not really know. I have never used picrate of ammonia or picric acid in this disease, nor would I use it or advise its use in such doses as Hammond advises. There may be cases calling for its use as a palliative (homœopathically), and at present we may restrict it to them.

*Veratrum viride* has been used in exophthalmic goitre. The following case is reported by Dr. Hutchins, of Madison, Ind.:

"Mrs. B. applied to me for treatment July, 1879. Height, above medium; weight, ninety-three pounds; age, thirty-five; mother of three children; her condition, anæmic; greatly debilitated; heart apparently much dilated, without rhythm, with a wallowing movement; eye globes so protuberant as almost preventing closure of lids, presenting shocking deformity; goitre not measured, but very prominent; mind deranged. She had suffered with this malady, gradually increasing in gravity, for twelve years. Had been under the treatment of several home physicians, and finally, while visiting in Philadelphia, consulted a physician of that city, who diagnosticated exophthalmic goitre, and advised her to return home immediately, as she was liable to fall dead at any hour. I confirmed his diagnosis, and placed the patient on tincture *veratrum viride*, three drops morning and night, to be gradually increased until the full dose possible to tolerance was obtained. At first the three drops were barely tolerated; four drops produced such weakness as to oblige her to take to bed for a short time. She persevered, however, until twelve drops were taken morning and night without producing nausea or any inconvenience whatever. This dose was continued twice daily for twelve months, then dropped to one dose daily for a few following months. The improvement of the patient was gradual but progressive, and at the expiration of twelve months from beginning of treatment the goitre had disappeared, the eyeballs had receded to their normal position, the mind had returned, and her weight was ascertained to be one hundred and sixty pounds. This lady was seen by

me only at long intervals during her treatment, but she faithfully obeyed orders, and took the medicine with the above results. She is now residing in this city in the enjoyment of good health."

This is a case remarkable for the persistence of the physician and the patience of the patient. *Veratrum viride* slows the heart without causing tension of the arteries. In this respect it is unlike any other drug.

*Cyanuret of zinc* has been used very successfully in many functional diseases of the heart. The symptoms are violent palpitation with sudden aggravations, accompanied by angina-like pain and a sense of suffocation, with vertigo and sudden unconsciousness. The pulse is quick and full, and there is general throbbing, with an internal tremulous feeling. The affinity of zinc for the brain, cortex and medulla makes it applicable to some forms of tachycardia due to paresis of the motor and sensory centres in the medulla, and to cases due to cerebral exhaustion. Dose, 2x trit.

*Ferro-cyanuret of potassium* is preferable to any other form of iron when there is slow and progressive anæmia added to the symptom indicating the zinc cyanuret. Several years ago I treated a case of chlorosis and Graves's disease with this ferric salt. The improvement was rapid and very satisfactory. I used the 1x trituration in 5-grain doses three times a day.

The moral treatment should not be neglected. The patients should be humored in their whims; not contradicted, but treated with kindness and consideration, and surrounded by the best social influences. All exciting scenes and emotions should be avoided.

They should be placed in a climate which agrees with them, avoiding the extremes of heat and cold or damp localities.

Prof. Nothnagel, of Vienna, in the course of a clinical lecture on Graves's disease, summarizes the treatment of his school as follows:

"Digitalis, according to common experiences, does not act at all on the tachycardia. It requires some firmness not to give this drug, but we may with comfort abstain from doing so, for it does no good. The same observation applies to the other remedies that act in the same way as digitalis. An effective agent against the palpitation is cold, in the form of an ice-bag, either over the cardiac region or over the neck. In some cases the palpitation, restlessness and excitement are made to disappear or are diminished by the application of cold to the neck sooner than over the cardiac region. These patients ought to live quietly and to avoid coffee, beer, segars, and mental and bodily excitement. Little or nothing is to be expected from medicinal reme-

dies. According to the most recent observations, galvanism through the medulla oblongata and cervical sympathetic is the best treatment; but this treatment must be regular and long-continued, and should be associated with a hydro-therapeutic course. The patient is then systematically treated in a cold-water institution with tepid half-baths, irrigations, wrapping in moist linen cloths wrung out, and the cold spinal bag. By this means, along with the mental quietness, an improvement in the condition is, in many cases, brought about. Iron can be given if indicated. In other cases, when patients are much excited, bromide of sodium or potassium may be exhibited in doses of fifteen grains twice or thrice daily. An important means of treatment, but one that can only be carried out in the cases of well-to-do patients, is to send them to the mountain regions, especially to the higher altitudes. By such a sojourn many cases are considerably benefited."

I have never tried such treatment, and I doubt the efficacy of cold applied as he recommends.

If Nothnagel's recommendation of high altitudes prove valuable, some elevations of the Allegheny or Rocky mountains should be advised, but, judging from the effects of elevations higher than five thousand feet, I think they should not go above that limit.

*Treatment of the Goitre.*—No local treatment is of much value. Applications of an ointment of the iodide or chloride of barium have, in a few of my cases, seemed to decrease its size. Phytolacca has appeared to be of some benefit; also spongia. Hypodermatic injections of iodine and ergotine have not resulted in permanent improvement.

*Treatment of the Exophthalmus.*—No special treatment has been suggested, until of late, by Dr. E. C. Sequin, who says in a recent paper, *loc. cit.* :

"*Bandaging of the eyes has never, to my knowledge, been practiced.* In the last two years I have tried it in two cases with excellent results; complete reduction of the exophthalmia in one case. A carefully moulded pad of soft cotton is placed over each eye, filling the orbit, and a light (of not more than three turns) flannel bandage applied with gentle but decided pressure. At first I do this for only an hour twice a day; later, for periods of two or four hours. In one of the cases the bandage was applied at 10 P.M., and allowed to remain all night. During the progress of the second case, which, though it has existed for at least three years, is much improved, I have made occasional ophthalmoscopic examinations without detecting any damage due to the pressure. The pressure should not be great, as it is intended simply to counteract the dilatation of vessels in the orbit, which is the usual immediate cause of the exophthalmia."

I have never tried this method of compression of the eyeballs, nor do I remember to have seen any previous recommendation of it, but I can see no harm from it if it is carefully practiced.

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AT almost the same date that Dr. Hale read the above paper before the Illinois State Society, Dr. Sansom treated of the same subject in a lecture before the London Medical Society. Dr. Sansom's address was delivered on May 5th, and published in full in the *Lancet* for May 10th. The following abstract was taken from the *Medical Record* for June 7th, and may be of interest to our readers :

The Medical Society's annual "Harveian Oration" was delivered on Monday last by Dr. Sansom, Physician to the London Hospital. Dr. Sansom took for his subject the consideration of certain cases of abnormal rapidity of the heart's action. He explained that he did not propose to consider any cases in which valvular or other organic heart disease was found to precede the signs of morbid acceleration. He also excluded cases in which the condition of rapidity was associated with states of disease accepted by general experience as predisposing causes of such acceleration—such, for instance, as fever, the direct influence of certain germs, marked anæmia, hæmorrhage, the operation of certain poisons and conditions of peripheral irritation, such as the presence of undigested food in the alimentary canal, and the sometimes pronounced effects of intestinal worms. Dr. Sansom also excluded cases in which the acceleration was solely paroxysmal ("paroxysmal hurry of the heart"), and also cases of palpitation, when such symptoms occurred in the case of a heart manifesting at the times when such palpitation was absent a normal rate of action. Restricting his review of cases to those not excluded for the above reasons, Dr. Sansom employed the term "The Rapid Heart" to designate the clinical condition met with. In some cases there was reason to believe the heart's action was quickened for very protracted periods. The limit of normal frequency was fixed by the orator at 90 in the adult; he thought we must regard as morbid a frequency exceeding this. (In children the cardiac pulsations were normally much more rapid, and were readily excited to a high degree of frequency by various intrinsic and extrinsic causes.) There were several classes of cases in which, in adult life, a long-persistent abnormal rapidity of the heart's action had been observed. In Graves' disease the pulse-rate might be 100 or 150, and under excitement might rise to 180 to 200; this acceleration of the heart's action was often the first sign, and might be for long periods the only manifest sign of the affection. The disease was serious and often fatal, and the chief cause of danger was in the cardiac involvement; in fatal cases the

heart was constantly found dilated and hypertrophied, but in no considerable degree. Another class of cases occurred in soldiers. Dr. J. M. Da Costa applied the term "irritable heart" to designate an affection he observed among the men engaged in the American Civil War. Dr. Da Costa observed more than three hundred cases of persistently quick action of the heart, and many of them manifested no obvious departure from health; the respiration-rate was not quickened *pari passu* with the pulse. "Rapid heart" had also been noticed in association with osteo-arthritis by Dr. Kent Spender, of Bath, who said: "The pulse quickens with the earliest objective signs of osteo-arthritis, there is a gradual rise until the numerical frequency of 110, 115, or 120 is reached, and there is scarcely any physiological variation during day or night. And the cardiac tumult does not always subside, even when the osteo-arthritic phenomena come down; a quickness and irritability continue which no medicine effectually controls." Cases of rapid heart without notable morbid association also occurred, and Dr. Sansom proceeded to consider such cases in detail. Dr. Bristowe had published nine cases, and excluding one of these on account of the co-existence of organic (valvular) disease, and another because the symptoms were more strictly paroxysmal, seven cases remained. In several of Dr. Bristowe's cases the patients were unconscious of anything abnormal. Yet five out of the seven cases died with signs which seemed to show that the affection was in casual relation with the deaths. One case ended in albuminuria and death after three weeks. In another, after undue rapidity of heart—the rate being from 200 to 260—had continued for six weeks, agonizing pain at the pericardium supervened, and the patient died with symptoms of pulmonary obstruction and failing heart. One of Dr. Bristowe's cases was ushered in by an attack supposed to be a sunstroke. Of six cases mentioned by Dr. Broadbent, one became hemiplegic and another died in convulsions. In one fatal case recorded by Dr. Bristowe, the heart was found *post-mortem* to be somewhat dilated and hypertrophied, but both the valves and the walls were healthy. In a case noted by Drs. Dreschfeld and Maguire, in which there was a history both of syphilis and of alcoholic excess, the heart was large and its tissue degenerated. The question arose whether the affection was one of the myocardium or of some portion or portions of the nervous system. Dr. Bristowe thought it had no special connection with cardiac disease, and that dilatation and hypertrophy of the heart, when occurring independently of valvular mischief, were the slowly-developed consequences and not the causes of the disturbance. On the other hand, Dr. Samuel West regarded cases of paroxysmal hurry of the heart as due to an organic lesion of the muscular substance, which might be in some cases a form of chronic interstitial myocarditis, consequent, perhaps, on rheumatic pericarditis or on syphilis, and thus related to fibroid disease of the myocardium.

## A VISIT TO KARLSBAD.

BY JOS. C. GUERNSEY, M.D., PHILADELPHIA.

KARLSBAD is nestled in the valley of the Tepl river, hemmed in on all sides by towering hills. Any one who has visited Mauch Chunk, in Pennsylvania, can form a fair idea of the situation of Karlsbad, as the two have very similar surroundings. Karlsbad is pre-eminently a "cure resort;" and to the cure, as practiced here, are three main factors: 1st. The numerous springs, the water of which is drunk, and the baths; 2d. Low diet; 3d. The quiet life and orderly habits. The class of patients usually sent here are those suffering from cardialgia, ulcer ventriculi, dyspepsia and catarrhal conditions of the stomach; constipation, intestinal catarrh; liver congested, fatty, or cirrhotic; enlarged spleen; gall-stones, gravel, catarrh of bladder, prostatic hypertrophy; anæmia; gout; adiposis; sciatica; some forms of skin diseases and gynecological troubles. As to diabetes authorities differ—but of this later. The number of jaundiced patients seen here, with skins yellow as saffron and often a dingy-brown, male (many of them army officers) and female is astounding. Another numerous class is the corpulent or obese, who come to lose their superabundant fat.

The narrow little river Tepl, filled with speckled trout, runs its rapid course through the town, and is kept scrupulously clean by the town authorities. The whole environs of Karlsbad are free from stagnant waters, and the town is exempt from intermittent fevers. The climate is that of central Germany, and the best proof of the clearness and salubrity of the air is that *Karlsbad has always been free from pestilential and epidemic diseases*. When cholera has run riot all through Europe Karlsbad has stood alone without a single case!

1. THE SPRINGS.—These are very nearly, if not quite, identical with "Glauber's salt." There are twenty or more, varying in temperature from 85° up to 166° F. Coming from the same basin, or a common reservoir, as they do, they all have the same ingredients, and in much the same proportion. The solid constituents are principally sulphate of soda, carbonate of soda, chloride of sodium (the greatest amount being the first named), carbonate of lime, of magnesia, etc. The principal difference in the use—for drinking—of the springs is in the temperature; and the local water specialists (physi-



cians) largely prescribe for their cases on this basis—"use water of such and such a temperature." The hours at Karlsbad are rigorously "*early to rise and early to bed.*" Before six o'clock in the morning the patients, or guests, undergoing the "*cure,*" are seen streaming in swarms to the respective springs from which they are to drink—the Mühlbrunn, Marktbrunn, Schlossbrunn and Sprudel perhaps leading in popularity. Even at this early hour the crowd soon becomes so great that long lines are formed at each spring, and a thirsty soul will sometimes be as long as fifteen or twenty minutes slowly working up for his turn to drink. Every person carries his or her cup hung by a strap around the neck. Arriving at the spring, the cup is placed in its order upon the receiving stand, is handed to a girl, who stoops and hands it down to a second girl, who stoops and hands it to a third girl, who fills it with the water and hands it to a girl above her, who hands it to the next girl above her, who places it in its order on the receiving stand on the side opposite to where the cup started. This is the order observed at the deeper springs. Where the water has been brought to the surface of the ground, the cup is simply received and filled. But the deeper springs are the more popular. At the Sprudel springs (the hottest of all, 166° F.) the water rises with great force, amid clouds of steam, several feet into the air; to obtain the water, cups are placed on the ends of poles eight to ten feet long, and then reached into the spring. Having received his water from his particular spring the recipient moves to one side, and slowly and solemnly sips it. The taste, the same at all springs, is not unpleasantly saline, enlivened with a little carbonic acid gas. The dose is from one-half to a whole cup; then he takes a short walk, or sits down for a little conversation, and in ten, fifteen or twenty minutes repeats the dose. This is done from three to six times. The water is almost universally taken in the early morning, on an empty stomach, although a very few drink again toward evening. From six to eight o'clock the bands of music play in the Sprudel colonnade, and at the Mühlbrunn. This music with the throngs of people slowly moving to and fro, and the sound of every language in the world being spoken, produces an effect to be seen only at Karlsbad.

**BATHS.**—The baths form quite a feature of the cure; they principally consist of the Sprudel-waters, vapor or Russian (*Dampfbad*), and the Mud-baths (*Moor-bad*). Printed signs at the "*Cur-haus,*" where these baths are taken, announce "*Genuine Pine Needle Baths.*" This consists in mixing a bottle of the Pine Needle extract into the

water of a Sprudel-water bath. Very hot temperature in any of these baths, except the steam or Russian, is not favored here; they average from 27° to 30° R. (from 90° to 100° F.). The baths are taken during the forenoon and in the afternoon. The mineral or Sprudel-bath is used as an adjuvant to assist the general water cure; to promote circulation; to reduce abdominal plethora, etc. The "Mud-bath" consists of a rich black peat, which comes from Franzersbad, a watering place near Karlsbad; this is mixed with the Sprudel water, and is then worked into a soft, sticky, clinging mass. I have tried all these baths, and I find the "Moor-bad" a special delight and luxury. The only trouble is to bring yourself to get into the mixture. Once fairly in—*dolce far niente!* It is prescribed for nervousness, sciatica, lumbago, gout, insomnia, etc., and for female weaknesses. Many cases of prolapsus uteri, accompanied by that "terrible, dragging-down pain and broken-in-half sensation" do obtain relief from these baths. The Russian steam-baths are on the same principle here as elsewhere.

2. DIET.—Between half-past seven and eight o'clock (morning), the crowds, which have been steadily increasing since six o'clock, begin to surge from the springs to the numerous cafés. These are in large rooms, restaurants, and they also consist largely of small tables in the open air, under the trees. To one of these cafés, or to a little table, the patient strolls, carrying in his hand, in a red paper bag, his favorite brand of bread which he has just purchased at one of the bakeries. There are from fifteen to twenty different styles of bread in Karlsbad, varying from the unsweetened familiar "Vienna roll" to the crisp, well-sweetened "coffee-bread." He orders his coffee or tea, usually the former, and one or two eggs. This is his breakfast—only this and nothing more. At noon, from 12.30 to 1 o'clock, the cafés begin to fill up again, and a full meal is taken, consisting of a light soup, roast meat, with a vegetable or two and a glass of beer or wine, or Griesshubler water, which is a mild sort of apollinaris, and comes from a spring a few miles from Karlsbad. At six o'clock, or shortly after, comes the last meal of the day—cold meat, an egg, milk, etc. The coffee is most excellent; the milk and eggs are fresh and delicious. The chief vegetables are potatoes, carrots, spinach and cauliflower; a few peas and string-beans, apparently canned. One who is not "taking the cure" can, of course, live more generously, and can obtain a wider range of diet than the above. But the variety, at best, is not large, and the well-fed American visiting this place merely from curiosity, or staying with a friend

who is under treatment, will sigh in vain for the lavish "bill of fare" handed him at any leading hotel in an American city. For instance, perhaps because it is forbidden to those drinking the waters, fruit is scarce. I have been here over five weeks, and now, June 12th, I have seen only the following: Lemons, fairly good; oranges poor, thick-skinned and no juice; wild strawberries, small and tasteless; cherries, not sweet. I do not know how the quantity and quality of the fruit may be later in the season; but, all things considered, Karlsbad is not a place for the gourmand or *bon vivant*.

3. QUIET AND ORDERLY HABITS.—Yes! the life here is quiet and orderly; it is quiet enough, save, perhaps, for the bands of music, for the strictest denizen of Ocean Grove, New Jersey; though neither high license nor prohibition prevail here, quite the contrary, indeed, there is no rioting, noise or loud talk. The gay belle of Saratoga or White Sulphur Springs would be sadly at a loss for her gayety, for there are no hops, no garden parties, and no late hours. *People come here to get well*, and they make such a serious matter of "getting well," that everything bends to this one end. There is a theatre here, and an opera-house, but in both, the performance begins at half-past six, and is over at nine o'clock. All the "Abend Konzerts" begin at half-past seven o'clock, and the last note is played as the clock strikes nine. The people immediately go to their lodgings, and by 9.30 or 10 o'clock there are but few persons to be seen in the streets, all the town being wrapped in slumber.

The hills surrounding Karlsbad are threaded by the most delightful walks imaginable, along gravelled pathways that, though they aggregate from forty to fifty miles, are kept in the most perfect order and absolute cleanliness by the town authorities. The dead leaves are carefully raked off; holes or ruts are repaired on sight; loose stones are removed, etc. Towers are planted on several of the hill summits, varying in height from 1635 feet to 2086 feet, and afford charming views of the country around.

Why these admirably kept walks? *Because they form a great part of the "Cure!"* Along them, and up the banks of the picturesque Tepl river, which in a degree resembles our own Wissahickon, every one strolls by order of the doctors, during the hours from breakfast to dinner. After dinner comes more strolling or sitting and listening to the music. There are several bands in Karlsbad; every afternoon from four to six, and evening, they have their regular places to play at. There is also considerable driving about in carriages to adjacent points of interest, as notably to "Giessbubl,"

a romantic drive among the Bohemian hills, distant about two hours. And some ride or drive the patient donkeys.

*What cases should not come to Karlsbad?*

Dr. Theodor Kafka, a courteous gentleman, is the only representative of our school of practice in Karlsbad. He has been there for eighteen or twenty years, and from his large practice has gained an ample experience. He has made considerable study of the above question and has deduced the following conclusions, which I have no doubt are mainly correct:

- "1. All the febrile phlogistic diseases and the acute exanthemas.
- "2. An excessive irritability of the vascular system, if the menstruation and the hæmorrhoidal flux are too copious.
- "3. Tuberculosis and pulmonary phthisis; all considerable suppuration of external and internal organs; ulcerated carcinoma of all organs; syphilitic ulcers.
- "4. Weakness from old age and all morbid conditions, with feebleness of the vital power and anæmia.
- "5. The following organic lesions: aneurism, atheroma of the great vessels of the heart and anchylosis.
- "6. Pregnancy in very feeble women, who are very thin, anæmic and with a disposition to miscarriage and to hæmorrhages.
- "The use of Karlsbad is useless, though not absolutely noxious,
- "1. In secondary syphilis.
- "2. In all important nervous diseases, in epilepsy, and in paralysis.
- "3. In organic faults and degenerations..
- "4. In cartilaginous indurations, the fibrosarcoma and abdominal tubercle.
- "5. Against the large calculi existing in the kidneys and the bladder."

Dr. Horatio R. Bigelow, in the *Boston Medical and Surgical Journal*, August 11 and 18, 1887, quotes the above and then says: "I would add to this list:

- "6. Bright's disease of the kidneys.
- "7. Diseases of the brain and spinal cord.
- "8. Malignant degenerations (as the waters often hasten death)."

What is it that cures at Karlsbad?

To my mind it is: 1. *The living in the open air.* Karlsbad life is entirely an open air life—walking, eating, sitting and resting in the open air.

2. The quiet and restful life one leads here; the early hours he

keeps; the entire abnegation of fashion's freaks and follies; the plain diet.

3. The influence of the place upon the patient's mind. He comes here believing he will get well, and intending to get well. He therefore rigorously leads the hygienic life that best conduces to such an end.

4. The fun of going to the springs in the early morning hours and *watching* the zealous enthusiasts slowly sipping their water, as though their cure really depended upon the imbibing of a given amount of it; inhaling the pure, sweet and cool air as yet unwarmed by the early sun; and the delight of listening to the well trained bands that discourse ravishing music. But does the water itself play no part in the cure? Yes, I think the *heat* of the water is decidedly beneficial. But the chemical or medicinal properties of the waters I do not approve of for general use. Karlsbad water can only prove helpful and curative to those patients whose symptoms correspond to the waters.

*Homœopathically.*—I have seen cases here which were directly injured, and their condition made worse, by these waters. Many homœopathic physicians have had experience with patients who have taken the waters at medicinal spring summer resorts, and who have been very sick as a result. I am a firm believer in hot water as a remedial agent in many troubles; and to a patient of mine visiting Karlsbad I would say, "drink a certain amount of plain hot water every morning on an empty stomach, take the homœopathic *similimum* from your own case and follow strictly the Karlsbad way of life—early hours, open air, exercise, no excitement."

*Gall Stones.*—From what I have seen and heard, it seems to me that the Karlsbad waters are homœopathic to many cases of gall stone. Certainly many and remarkable cures have been reported. The most eminent authorities assert that the water does *not* dissolve the stones, but its curative action is wrought by thinning the bile and restoring it to a normal condition, "thus the formation of fresh concretions is evidently prevented." Dr. Kafka, referred to above, writes in his brochure, "Karlsbad water not only facilitates the passage of the small stones already present, but it dissolves also biliary matter in process of transformation into calculi, and delays for a long time the formation of new calculi." I fully believe that many persons suffering from gall stones would be benefited by a sojourn at Karlsbad.

*Diabetes.*—Here is a decidedly mooted point; and eminent au-

thorities differ widely as to whether the waters, *per se*, are curative. It is admitted by all, that cases of diabetes do improve here; and, in all probability, the chief if not only factor in this improvement is the strict attention paid to anti-diabetic diet. A patient can be more rigidly held down to diet here than any place I know of. He is certainly freer from temptations to err in this than he could possibly be in his own home.

*Adiposis*.—Many there be who sing praises to Karlsbad for the relief they have had in losing *pounds upon pounds* of their “too, too solid mountain of flesh.” I am inclined to attribute this improvement also to the low and anti-fat diet, to the constant walking, and to the warm baths. There are cases known here where patients have lost, in a two months’ stay, sixty pounds, or a pound daily, and this, too, without any apparent ill effect to the loser; indeed, his general health and bodily comfort seem much improved in every way.

There are also many remarkable cures of *gout* and *gravel* reported—due, *me judice*, to the mode of life here, and when the medicinal effect of the waters is homœopathic, as it seems to be in many cases of the above.

My theme is tempting; did time and space permit, I would be glad to go more deeply into the matter, and write in detail of all the class of ills which come here for aid. But, as this may not be, I will now refer to the cost of residence here, and the most attractive place. There are *any quantity* of lodgings, and they accommodate over 28,000 annual visitors. They can be had at all prices, but the most expensive do not cost so much as one would pay for the same accommodations at Saratoga or Cape May. The “Grand Hotel Pupp” has the prettiest, and, all things considered, most convenient location. Every one staying at Karlsbad passes and repasses here; there is abundance of music, fine large cafés, both open air and enclosed in glass, etc. It is, too, probably the most fashionable. It is always full, and rooms are engaged months in advance. Residence on the Schlossberg street is also very desirable, and on account of its elevation the air is sweet and pure.

I must make a closing remark on the Karlsbad waters. Whatever efficacy they may possess is, in the opinion of able judges, greatly impaired if not wholly lost when bottled and transported. Writes Kafka: “The action of the water is entirely different when exported in bottles or imitated artificially, showing that elements of which chemistry has only disclosed traces play an active part in the cures effected by these waters. . . . The waters of Karlsbad work only

their wonderful and extraordinary effect when one drinks them at the springs themselves; the carbonic acid evaporates in the transport." Writes Bigelow, quoted above: "There is, too, potentiality for good in these waters taken at their natural temperature, with their proper admixture of carbonic acid. A potentiality which no imitation can possibly obtain, and which, even the bottled waters will fail to accomplish. Chemical combinations become changed, not only in their molecular formation, but in their therapeutic action, by the action of heat. Proof is not wanting that cases in America, under the most intelligent handling and favorable circumstances, failed to respond to a therapeutical system based upon a knowledge of the ingredients of the Karlsbad waters."

To the foregoing I will add, that the mere losing of temperature is not all, for when reheated, before being uncorked, their virtue is not re-established.

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## ON THE VALUE OF CONCOMITANCE AND SEQUENCE OF SYMPTOMS.

BY M. W. VANDENBURG, A.M., M.D., PORT EDWARD, N. Y.

(Read before the American Institute of Homœopathy.)

THE basic doctrine of homœopathy is, that to cure a natural disease by the shortest, safest and surest method, it should be matched, in all its important and leading manifestations, by a sickness that has been produced upon some healthy person, as the direct result of the action of some drug, and that this drug, when administered in small doses, or in repeated small doses, will invariably cure the natural disease.

The claim of homœopathy is, that any substance, which, taken into the healthy system, deranges the state of health and, as a direct result, produces sickness, may be used to cure a very similar natural sickness, and that it will invariably cure such sickness.

When a homœopathic prescription fails to cure, the fault is generally laid at the doctor's door, and among the excuses given are the following:

First. Some diseases are incurable, or seem to be, as far as we can see.

Second. There comes a time when the forces of life must yield to the inevitable; death is certain for all.

Third. A most comforting doctrine, to account for the incurable cases, has lately been evolved from the inner consciousness of a disciple of Hahnemann, to wit: that incurable diseases are so, because they do not manifest all their symptoms.

These three excuses lay the blame on the nature of the disease; they are all, to a certain extent, fallacious.

The first, that some diseases are incurable, begs the question, and is without warrant from a scientific standpoint. Many diseases, formerly so regarded, have proven curable under the reign of a broader knowledge.

The second is of a like character. Death should never come to a person who has maintained a proper hygienic life, and been free from accidents, and from inherited evils, except as a painless vanishing of the vital force. Disease has no place here, under a perfect homœopathic treatment.

The third, that all diseases do not manifest their symptoms, is a subterfuge. Old Hahnemann has called it by about the same name.

It now remains to impugn the law, or to look for the excuse elsewhere. As to the law, "every carefully conducted experiment" will prove, that the thoroughly homœopathic remedy will invariably, rapidly, thoroughly and permanently cancel and turn into health the totality of symptoms of the diseased conditions (S. 25)." All genuine homœopathic experience turns this way. No counter tide has ever been established by any carefully conducted experiments.

As shown above, failure cannot be attributed to the nature of the disease; hence, we must look elsewhere for the cause.

The reason for failure most frequently assigned by the would-be-critic, is, the doctor did not study his case carefully enough, or he did not study his *materia medica* with sufficient attention.

Doubtless, the blame does often lie here; experience proves this when some one else steps in and cures the case.

Another cause of failure, one mentioned by Hahnemann (Sa. 162, 163), is, the exact antitype of the disease cannot always be found in the proven drugs; it does not exist. As Hahnemann pointed out, the excuse in this direction should grow less and less with every fresh addition to our *materia medica*. This is doubtless true, if all the additions were reliable. But it is undeniable that a large bulk of material has crept into the symptom list, that is only very imperfectly demonstrated; this greatly increases the bulk, dilutes the reliable part, and casts a suspicion over the whole. The physician, for the most part, goes to a list of symptoms, wholly undistinguishable



as to their origin, all placed on the same footing, and from this he must construct his disease antitype.

Here is the real cause for failure, and one that must, in the future, be remedied. When that has been properly done, it will be found, there is less excuse; that the counterpart of this disease does not exist in proven remedies.

There remains still another, and, it seems to me, a very serious reason for failure in prescribing, and that is, the faulty arrangement of accepted materia medica, which is not only misleading, but, also, unavoidably misrepresenting, as to facts, and with a direct tendency to subvert the application of the homœopathic principle.

To avoid confusion, let us again recur to fundamental principles. From these it naturally follows, that the sickness produced by the drug should, in all its important points, resemble the natural disease. In other words, if you were called to see a patient who had been poisoned by belladonna and were told it was a natural disease, you would, first of all, think of giving belladonna.

Ordinary observation establishes the fact, that in the cycle of every natural sickness, the group of symptoms changes from day to day as the disease progresses. Certain symptoms belong to the onset, others to the height, others still to the decline. This is equally true of drug-diseases, as shown in drug-proving.

If now we bear in mind the theory everywhere urged from Hahnemann's time to our own, that it is the totality of present symptoms that must be met by the drug-sickness, we will see at once how futile would be a diagnostic picture of the case, were the symptoms of the rise of the disease, its height, and its decline commingled and blended in one impossible group.

If this be true of the natural sickness, how can it be supposed to be less futile with regard to the drug-sickness? What is there in the homœopathic law, or in experience that warrants the indiscriminate commingling of symptoms from the beginning, the middle, and the end of a drug-sickness, into one impossible drug-picture?

Nay more, what is there to warrant the taking of one symptom from A, another from B, another from C, and so on *ad infinitum* to construct an impossible drug-picture.\*

Hahnemann attributes to each drug certain definite powers, and in this he is probably correct. But there is in these peculiar drug

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\* I am well aware of Hahnemann's theory regarding epidemic diseases and epidemic remedies, *Org.* 8. 101, 102. But this seems to me of very limited application.

powers as combined in each drug, also a certain con-association, a certain concomitance of appearance, that marks their manifestation, and which, within certain limits is not overstepped in any drug-proving; and it is this concomitance that contributes more than anything else, to the absolute certainty of a homœopathic cure. As far as my own experience and observation have gone, *concomitance of symptoms* in a drug-proving seems to be necessary to insure a cure; and failure has never followed when this element has been present.

I do not stand alone in the opinion that concomitance is an important element to be considered in selecting symptoms to form the antitype of the diagnosed natural sickness.

Carroll Dunham says on this point (vol. ii., p. 54), "you must study the connection and succession of symptoms, to be able to prescribe in this large viewed way for your patient."

But connection and succession of symptoms is just what the Hahnemannian arrangement most persistently ignores.

What is the result?

First, there is a visible falling away from strict homœopathic principles among homœopaths themselves. After having laboriously constructed a drug-diagnosis to correspond to the sickness-diagnosis, the physician finds that it does not invariably cure his patient. He is not conscious of any lack of diligence on his part, and he comes to suspect his tools. If a workman uses incorrect tools, he will arrive at correct results only by chance, not by skill, and it is by chance rather than by skill that a correct drug-picture is constructed from the received *materia medica* of to-day.

If I may be allowed to again reiterate my principles of faith, I will say that I believe, when any case of natural sickness is properly diagnosed as to its totality of present symptoms, and with due regard to its past history, and when this totality has been matched by a drug-sickness as manifested in its totality at a similar stage of its progress, and with a due regard to its past history—then the natural disease will invariably be cured and obliterated in its whole extent by a very small dose, or by small doses frequently repeated of the drug thus determined.

This seems to me to be the homœopathic law in its real essence, and I believe every carefully conducted experiment, and every genuine experience will prove it *true*.

## THE TREATMENT OF ENDOCARDIAL COMPLICATIONS IN THE DISEASES OF CHILDREN

BY WILLIAM W. VAN BAUN, M.D., PHILADELPHIA, PA.

(Read before the American Institute of Homœopathy, June 19, 1890.)

THE intimate association of rheumatic arthritis, chorea and endocarditis, together with the well-established fact that endocarditis is not a primary or idiopathic condition, if we omit direct injury as a cause, gives to the subject of the preventive and remedial treatment of endocardial complications a far-reaching importance. In considering the diseases with which an acute cardiac inflammation is apt to be associated, rheumatism naturally stands out in bold relief. So well is this relationship understood in pronounced cases, that the attendant is at once on his guard for the cardiac attack. The important point, however, is the recognition of the danger of the heart in cases in which the symptoms are not well defined or are altogether wanting. The successful handling of endocarditis depends on its early discovery and treatment; it is, therefore, essential always to be on the alert for the possible complication. For example, children suffering from slight attacks of fever, with obscure pains, should suggest to our minds two good points of routine practice; first, to make frequent examinations of the heart with the stethoscope, and secondly, to search carefully for joint tenderness, remembering that in chubby children redness and swelling of the limbs are usually absent. Again, in children of rheumatic parentage, we are not to lose sight of the possible rheumatic origin of the attacks of pains in the legs, with or without pyrexia, which are so frequent in childhood, and also in such diseases as tonsillitis, pleurisy and pneumonia, even if the leg pains are absent. If such cases are dependent on latent rheumatism the condition of the heart is in grave peril. It is in just such a state of affairs that we are to look for an explanation of the cause for the frequent existence of mitral stenosis in young women, and we can easily convince ourselves that the condition is the result of an undiscovered rheumatic endocarditis in early youth. This association of chorea, rheumatism and endocarditis has of late been greatly dwelt upon. Statistics show that the cases of chorea with endocarditis as a complication are usually those coupled with rheumatism, the natural inference being that the endocarditis of chorea is of a rheumatic origin. But it is an admitted fact that there are cases

of chorea with acute cardiac inflammation as a complication, where a rheumatic history cannot be traced. Consequently we are to watch the heart of every case of chorea with the greatest care. Heart inflammation is liable to occur in scarlet fever, diphtheria, measles, tonsillitis, septicaemia and purpura rheumatica. In all of these diseases, especially in children, the endocardial inflammation creeps on insidiously, and is likely to be sub-acute. If there be no secondary pericarditis or myocarditis it may run its course without attracting attention, there being no præcordial pain, palpitation, dyspnoea or distress of any kind, and, on auscultation, it may be impossible to demonstrate the presence of a bruit, and yet the subsequent history of such children will show the development of a serious valve lesion that can be accounted for only on the ground of an unrecognized endocarditis. The knowledge of such cases must make us suspicious of cardiac danger in all cases of rheumatism, no matter how trivial the symptoms. I coincide with the opinion that, in the majority of cases, chorea is simply an expression of a rheumatic diathesis. A careful examination of the hearts of children complaining of slight rheumatism, scarlatina, chorea, erythema, tonsillitis, nephritis, pyæmia, etc., where the fever and other symptoms are possibly only slight may reveal an unexpected valvular murmur, the early recognition of which, leading to proper treatment, will save the little sufferer from a wrecked and stranded existence. In other words, we are not to wait for patients to complain of heart symptoms. Expectancy and constant watchfulness will enable inspection alone to warn us of the earliest cardiac involvement. The expression of the face, the increased difficulty in breathing, no matter how slight, the working of the alæ nasi, the posture in bed, the restlessness, etc., all indicate the oncome of the endocardial complication. In taking up for consideration the treatment of rheumatic endocarditis, the chief clinical feature brought to our attention is its tendency to repeatedly relapse and recur. Under careful treatment the temperature may fall to normal, the restlessness disappear and all the symptoms abate, the child, seemingly, convalescing splendidly. Suddenly, without cause, or from causes apparently in themselves trifling, the inflammation revives with all its old vigor and danger. Thus the condition may run a most persistent and protracted course. This striking feature in the clinical history of endocarditis shows the remarkable obstinacy of the rheumatic poison, and leads us to the first great essential point in our treatment; that is, the necessity of persistent effort—the patient must be kept under medical inspection for a long time. Any half-

hearted management will lead to disastrous results. The peculiar susceptibility of children to impressions is very apt to be overlooked. All of us can probably recall cases of endocardial complication apparently on the high road to recovery under careful treatment, all routed and upset, the patient worse than in the beginning, the cause being a simple change in the diet, an error in the temperature of the room, the visit of a playfellow, the parting of a nurse, an exciting story, a sudden fright and similar circumstances. In a recent case I found a rise of temperature of four degrees, a return of rheumatoid pains, oppression in breathing, etc., in less than four hours, all of which was attributed to a sleeping convalescent being awakened in terror, in the dead of night, by the rumbling and clattering of racing fire-engines. Any of these causes may, in susceptible childhood, be the means of bringing our best effort to nought and our patient a serious relapse, besides straining the relationship between the physician and family. The latter, not being able to appreciate the reason of such repeated relapses, it becomes the duty of the physician, both to himself and the family, to explain in the very beginning of the case this disposition to recurrence, and to insist upon the most scrupulous care and persistent effort in behalf of the little patient long after all apparent signs of the trouble have disappeared.

Our first care will be the prevention of the cardiac complication, and the greatest prophylactic at our command is *heart rest*. In those cases where we suspect this liability we are to use every endeavor to cut short the underlying diseased condition. If it be of rheumatic origin the endocarditis is likely to appear during the first week. If the patient can be piloted, by persistent and careful effort, through the violence of the first week of the rheumatic storm, the complication will probably be avoided. The means to accomplish this end are, first, the remedy best suited to the individual case, assisted by a competent and vigilant nurse, the avoidance of chill, which is especially apt to occur, and, secondly, a rigidly fluid diet, richly nutritious, but non-stimulating.

When the complication—endocardial inflammation—really exists, we are still to insist on rest—absolute rest—bodily and mental, kept up long after all signs of endocarditis have disappeared. Exertion of all kind increases the action and force of the heart and favors the development of inflammation; while mental excitement will surely give rise to increased cardiac action. The necessity of rest cannot be too much emphasized. Rest in bed means the restriction of muscular effort in every possible way. The patient is not to use his

hands where it can be avoided; the holding of a picture-book is especially objectionable. The nurse should anticipate all demands and supply all requirements. The feeding is to be accomplished with the aid of the invalid's cup, or the bent tubes; the bowels, which must be kept regular, and the bladder are to be evacuated with the use of the bed-pan and urinal; the personal comfort of the patient is to be most zealously attended to; this will tax the best judgment and ingenuity of the physician, nurse and parents. The diverting the mind of a pampered child from an ever-returning craving for some simple but harmful article of solid diet, which must be resisted, no matter how trying to the parents, and must be done in a way that will calm and not excite the patient, will often-times require of the attendants the attributes of an angel. A meal of solid food will excite the circulation, quicken the cardiac action and act banefully on the inflamed lining membrane of the heart. Stimulants are only to be used where they are demanded by cardiac failure, and then with the greatest caution. A characteristic feature of the indefinite relapsing form of endocardial complication, which drags along week after week, month after month, is a progressive anæmia, sometimes associated with wasting. This tendency will be difficult to overcome. The internal treatment will naturally be the remedy that covers the totality of the symptoms of the individual patient.

In rheumatic conditions aconite has served me well, in the beginning, in the state of hyperæmia preceding the valve changes, the pulse being small, hard and quick, with pains of a sharp, pricking character in the præcordium, associated with faintness, oppression, together with tumultuous action of the heart, causing anxiety and fear of death. If aconite does not speedily relieve, spigelia has been almost a specific in endocarditis. It corresponds to the disease; the pains are severe, shooting or stabbing in character, with a distressing oppression in the chest, the least motion producing exhaustion and suffocation. The palpitation at times is very violent, the movement of the chest-wall being quite perceptible. The patient cannot lie down. If the palpitation persists after the use of spigelia, spongia has proved to be a valuable remedy; it also follows aconite well, it comes in after the exudation of fibrine and tends to limit the deposit. *Veratrum vir.* is useful in cases with violent congestion, pain and intense force of circulation. Headache of an acute throbbing nature, without delirium. With rest, an absolute liquid diet, and these four remedies I have usually been able to abate the inflam-

matory action and shorten the duration of an attack. *Kali hydriodicum* is a useful remedy in the relapsing endocarditis of rheumatic origin, where there has been an eruption of subcutaneous fibrous nodules. *Bryonia* will be the remedy for the complication when it is secondary to pleurisy or pneumonia. *Arsenicum* is indicated during or after the suppression of measles or scarlatina, where we have the characteristic restlessness and agony of the drug, with tingling in the fingers, especially of the left hand, together with dyspnoea. *Phosphorus* is a neglected remedy in endocarditis; it is of particular value where the endocardial complication arises during the course of an acute rheumatism, in rapidly-growing children who are excessively susceptible to every impression, be it pleasant or otherwise. When associated with chorea I rely on *arsenicum*, *cimicifuga*, *mygale*, *phosphorus* and *verat. vir.* If the complication is recognized early I depend upon *aconite*, *ferrum phos.*, *spongia*, *spigelia*, *bryonia* or *phosphorus*, whereas, if the disease is advanced, then dependence is placed on such remedies as *lachesis*, *hydrocyanic acid* or *arsenicum*.

When the primary disease, such as rheumatism, chorea, scarlatina, etc., has subsided and the restoration of the various functions indicate that convalescence is well established, I feel that I am entering upon the most difficult stage of the treatment. It is so hard to bolster up the moral courage of a fond mother to the point of resistance of the oft-repeated pleadings of a loved little one "to get up," "hold me in your lap just a little while," and the thousand and one other things that suggest themselves to the active brain of our frail physique city children, with the highly developed and over-wrought nervous systems. We are never to lose sight of the recently inflamed endocardium, and that in all probability it is still in a condition of great physical weakness and the seat of new cell growth. If we turn a dull ear to the mutterings of attendants and persist in our demands, we will, in the majority of cases, be able to impress on our families the necessity, if not the reason, of a most jealous avoidance of actual exertion for weeks, and the need of a most careful and gradual return to exercise. If we succeed we will save our patients from results that would otherwise be disastrous, and while we may feel that our best efforts have not been appreciated, we can console ourselves with the conscious rectitude of our purpose.

## CAN CRIMINALS BE REFORMED BY MEDICAL TREATMENT.

BY GEORGE W. BOWEN, M.D., OF FORT WAYNE.

(Read at the Twenty-fourth Annual Session of the Indiana Institute of Homoeopathy, Indianapolis, May 15, 1890.)

WHAT are the causes that induce the commission of crime? Woe and want are not the only ones. Some inherit a tendency to trample on all the barriers of restraint that are placed for the protection of the masses. Some have only one vicious tendency, as in kleptomania. Some acquire in later years, from habits and society, a criminal inclination, and by slow degrees become confirmed.

Legal restraint may hold in check, but never cures one of a vicious or criminal inclination. Temporary confinement may prevent, for the time, the commission of any overt act, but never removes the desire to overreach some moral or legal barriers when an opportunity shall offer.

Is it not time to investigate this class of individuals, with their various predilections, and see if some measures cannot be devised that may prove to be of value to them, and that may serve to shield society from their depredations, by mitigating their propelling influence or promptings in that direction? Doubtless, with a certain class, measures can be devised that will be more effectual, reasonable, and less expensive than the mechanism of legal enactments.

In all other departments of life and the necessities of society, a consistent progress has been made—but in the management and treatment of criminals, none.

Compulsion and terrorism are the principal factors that are considered in the efforts for the conservation of the peace and equity of the masses.

Does arrest, conviction, and restraint offer more than mere palliation? It must become us, as, to a certain extent, guardians of the public weal, to consider this subject and see if it is not in our province to render some essential service that may prove to be of more utility than the means and measures that are now relied upon, and have not proved to be as effective as could be desired. Causes that may be the prompters to acts must be considered if a prudent analysis of the subject is to be made.

We have evidence of the ill effects of drugs amply enough to demonstrate that the brain and its appendages can be impaired by a



local or general engorgement of blood, and to such an extent as to render the person incapable of rational or connected thought. Also, that the same condition can occur or exist arising from extraneous or natural causes, without the direct interposition of drugs. A long continuation of that condition will more or less embarrass the healthy or normal action of the brain and vary his cerebation.

This condition, if from diseased action, our profession are generally enabled to restore by the interposition of medicine designed to relieve the congestion, or control the inflammation that may have ensued, and eventually repair the damage that organ may have sustained.

The insane are not amenable for their imprudent acts owing to their physical defects or their incapability of correct reasoning.

Many persons considered sane are more or less liable, and do have a passive congestion of blood to the brain, that eventually causes a thickening of the dura mater, resulting from the occasional engorgement, and a defective circulation through its cortical substance. Dyspeptics are far more liable to acquire this condition than the public in general. They, of course, are to a certain extent the authors of their own misfortunes.

The imprudent indulgence in the use of alcoholic drinks is certain to cause a diseased condition of the brain, and to such an extent as to carry the habitual user beyond the point where correct reason can reach to safely guide. His morals are held in abeyance, and impulse holds the rein to which he readily obeys.

The morphine eater becomes lost to all honor, and sinks to be the basest slave, with but one want to feel and know. With that drug, the brain and all the grand connecting links of nerves are lured to a repose akin to death, until the drug has ceased to hold its fond embrace, and nature ceases to rebel.

Can we still say, it is but a habit, and not admit the brain has lost its sanity.

Let us consider those that cloud their brain and cause their own misfortunes by their own indiscretions, and that class from which at least nine-tenths of the criminals have birth. Intoxicating drinks are the primordial or producing cause of crimes of all forms and phases. This is a well-comprehended fact by all jurists, and is considered as an important source of revenue by the younger members of the legal fraternity. But a growing desire has sprung up with those devoted to medical jurisprudence that the medical fraternity should come to their aid, and take under advisement the bearing

that medical treatment will have on those designated as criminals or become such by the use of stimulants. That their use does induce to crime is madness to question, since those dealing most especially with criminals realize this to be the case. Judge Gary, of Chicago, says, that in his long experience on the bench he has found that nineteen-twentieths of all the crimes committed were from the one result of drinking. Judge McAdam, at a meeting of the Society devoted to Medical Jurisprudence, in New York, April, 1890, took up the legal and medical question of drunkenness, and made a plea for some legislation which will tend to protect a drunkard from himself, and save his wife and family from ruin. He advocated the passage of a law which will allow the courts to confine a man in some institution when two physicians sign a certificate to the effect that his passion for strong drink makes such a course advisable. A long discussion followed the reading of the paper. It was the general opinion of the speakers that drunkenness should not be treated as a crime but as a disease, and that men should not be sent to penal institutions for drunkenness, but should, instead, be confined in some sanitary institution until cured of the weakness.

Can we refuse to coalesce with the legal fraternity, when they so fully comprehend the situation and desire our assistance to not only protect the individual against himself, but to shield his family and the State from his insanely vicious vagaries and induced outbreaks?

When the habit is so acquired and depended upon for the sustaining of the energy or to keep up the nervous system, he has really arrived at that point where he should be classed as an invalid, and needs to receive treatment for his diseased condition. His is a nervous affection, and stands in the category next to insanity. Some demented persons have only one fanciful freak or strange hallucination, but sane in all else.

A hyperæmic condition of the brain, or the meningeal membranes, caused by new invading or a former diseased condition, can be called into activity, and aggravated by certain drugs, and temporary or permanent ill results may ensue, not entirely devoid of danger. These cerebral disturbances are caused by substances taken into the system to stimulate and increase the circulation through that organ to its detriment.

Nor are all the detrimental effects of enforced circulation confined to the brain, with its violent outbreaks, to be followed by its fearful results; but it may embarrass by congestion the sexual organs, and

cause an orgasm that brooks no control, and the result is a blasted life, death, or infanticide.

There are many pathological conditions of the brain that will superinduce or cause a tendency to criminal acts that could be remedied by medical treatment, but our only effort should be confined to those that have or will impair their cerebration by the injudicious use of alcoholic preparations. The desire for its habitual use and its ill effects can be easily and entirely eradicated from the system by the judicious use of medicines that will in no way be detrimental to him or his interest, either at the time or in the future, and after a complete restoration he can again enter the arena of life with brighter prospects than the past could offer.

The question may arise in regard to the legality of depriving a person of his liberty even temporarily, but as the State has assumed to take the care peremptorily of those who are demented, or are disseminating some infectious disease, for their own and the public interest, why may it not assume more? The same reasons would apply to habitual drunkards.

Only a few months (from one to three) of enforced restraint and treatment in a sanitarium would restore them to a healthy and normal condition, and prove a blessing to them and their dependents.

As our school of medicine has a perfect knowledge of the drugs essential for the restoration of this class of cases, and lessening the increase of criminals that spring from this cause, it would seem appropriate that we, as a State medical society, should ask the State to consider the propriety and the necessity of the enactment of some law having in view the restraint and cure of those who habitually get intoxicated, and either become vicious, or neglect those that are dependent upon them, and thereby entail the chance of their becoming a public charge.

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## CORRESPONDENCE.

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### A PLEA FOR THE SECRETARY.

THE office of Secretary of a Medical Society demands at the hands of the profession some special consideration. I write with a hope that this brief communication may impress the members of our various societies, State and local, with the existence of this necessity and with the consequent justness of what is here proposed. Only

those who have served as Secretary can have any full appreciation of the very laborious duties that fall upon the incumbent of this office. Our national society, the American Institute of Homœopathy, pays its Secretary a salary. Small as it is, it is a recognition of his services and a partial payment for the work he performs. The State or other society that pays nothing finds it necessary to make frequent changes of the incumbent of that office; for no member can afford to carry on the work long without remuneration. These frequent changes detract very much from the efficiency of the work to be done. If a society can afford to pay a salary, it should do so. If not, then I propose instead of that, that it shall create the office of "Honorable Secretary," as is done in English Societies; and that, at the end of the first year of service the Secretary shall be eligible to such election. He thereby holds his office and a desirable title without payment of fees. His travelling expenses should, while he holds the office, be included in the general expense account. Upon retirement from office he remains, in perpetuity, Honorable Secretary without payment of dues. This may be a small return, but it costs little, and lightens the burdens which he carries while on duty. All our societies which now make no compensation to the Secretary, should, at the earliest moment, make some such provision; and it is to be hoped this suggestion will meet with a ready response.

T. P. WILSON.

Detroit, Mich.

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#### CORRIGENDA.

MESSRS EDITORS OF THE HAHNEMANNIAN MONTHLY:

GENTLEMEN.—In the issue of your journal for June last, are some typographical errors to which we wish to call attention, and those of your readers who are sufficiently interested in reconstructed materia medica, can follow the subjoined corrections and make the necessary alterations in the symptomatology of apis, as published in the paper entitled "A New and Scientific Materia Medica Based Upon Pure Pathogenesy."

Very respectfully,

*The Medical Investigation Club of Baltimore, Md.*

Page 355.—Under "Generalities:"

Second line.—After "lassitude" put a period instead of a semi-colon; and "weakness" should begin with a capital, and be followed by a colon instead of a semi-colon.

*Under "Mind: "*

First line.—A period should follow "agitation" instead of a semi-colon. "Great" should also be followed by a period, and "irritable" should begin with a capital.

*Under "Head: "*

First line.—"Head" should be followed by a period and not by a semi-colon, and "vertigo" should begin with a capital.

*Under "Eyes: "*

Sixth line.—"Eyeballs" should be followed by a period instead of a semi-colon, and the next word, "swollen," should begin with a capital.

*Under "Nose: "*

Second line.—A period should follow "nose," instead of a semi-colon. "Sneezing" should begin a sentence and be followed by a colon, instead of a semi-colon.

*Page 356.—Under "Abdomen: "*

Third line.—"Diarrhœa" should be followed by a period instead of a semi-colon, and the following word, "abdomen," should begin with a capital.

*Page 357.—Under "Chest: "*

Second line.—A colon should follow "chest," instead of a semi-colon.

*Under "Heart and Pulse: "*

First line.—"Heart" should be followed by a colon and not by a comma.

*Under "Neck and Back: "*

Second line.—"Neck" should be followed by a colon, instead of a semi-colon.

*Under "Limbs: "*

Fifth line.—The exponent "2" after "hands," should be "4."

Ninth line.—After "swollen" there should be a colon, not a semi-colon.

*Page 358.—Under "Skin: "*

First line.—A colon should follow "body" instead of a semi-colon, and a comma should follow the succeeding word, "itching," instead of a semi-colon.

Second line.—"Skin" should be followed by a comma instead of a semi-colon.

*Under "Sleep: "*

First line.—A colon should follow "sleeplessness."

Second line.—A period should follow "night" the succeeding word, "dreamful," should begin with a capital, and the next word, "sleep," should be followed by a colon instead of a semi-colon.

*Under "Chill, Fever and Sweat: "*

Second line.—A period should follow "fever." "Sensation" should begin with a capital, and the succeeding word, "heat," should be followed by a colon.

## EDITORIAL.

## HOMŒOPATHY AND THE "INTERNATIONAL" COMMITTEE.

HOMŒOPATHY to-day stands as a separate and distinct school of medicine—Catholic in the full acceptance of the term—with the characteristic corner-stone of liberality of sentiment. The origin of this school of medicine was not of selection but of necessity, the arrogance, bigotry, intolerance and prejudice of the allopathic or so-called "regular" school of medicine being responsible for its existence. This new school of medicine includes not only zealous therapeutists and enthusiastic materia medicists, as of old, pursuing their elected branches with a passionate earnestness and absorbing devotion that commands the admiration and respect of every thoughtful and sincere member of the profession; but it also embraces men who have branched out and are pressing eagerly and strenuously forward in the line of every known speciality in medicine. These men are giving the best effort of their lives to surgery, diagnosis, gynaecology, obstetrics, ophthalmology, pathology, bacteriology, etc., and such is the activity, energy, intentness and overwhelming power with which they have pursued their way in the face of all opposition that in America, at least, they stand the peers of any in the medical profession, and, in some instances, all their peers in ability surpass. With these men therapeutics and materia medica are, rightly, not the chief end of their medical existence. They accept the Law of the Similars, not because Hahnemann was prophet, but because the law is true, and they accept truth for truth's sake. They are always ready to receive anything the specialists in our materia medica have to offer, and they are willing and stand prepared to do all in their power to uphold, strengthen and encourage our therapeutists in their herculean labor. They also believe in the present, and in the present homœopathy does not represent one or two branches of medicine; it is now a *school* of medicine; broad, liberal and progressive.

All the twelve thousand homœopaths in the United States glory in the development of our materia medica and therapeutics; and all stand as a mighty unit in loyalty to homœopathic organization.

There are many, however, yes, thousands who are opposed to being hedged in by a "pent up Utica," and who consider it unfortunate that the Committee on the International Congress in 1891

have adhered to the old policy of restricting all essays and discussions to "all the leading *topics* of medicine especially *associated with and influenced by homœopathy*." All will agree with the committee that "such consideration and discussion must prove of great interest and value" and be of "great importance to the progress of medical science." Every word of this we know to be true, but why does the committee place restriction on the character of both essays and discussions? They have rightly pointed out the main trend the work of the Congress should take, but why has not provision been made for our surgeons, our gynæcologists, our diagnosticians, etc., to present their essays and to discuss their specialties in the broad sense rather than in the line of homœopathic therapeutics only? The advance in these specialties during the past five years has been marvellous, and as a school of medicine we are interested in every topic of medicine whether it be, or be not, especially associated with and influenced by homœopathy. We know we are voicing the sentiment of the majority of the profession when we urge upon the International Committee to reconsider the strictly therapeutic stand they have taken, and ask them to broaden the lines of both essays and discussions so as to meet the demands of all interested in the success of the coming Congress. Our "old" school opponents have long since, by all that is fair or foul, been trying to characterize our school with wretched narrow-mindedness. This is false, absolutely false; such being their intent, however, we should do nothing to give the accusation even the semblance of truth. We are to show to the world in unquestionable measure that as a school of medicine we are conversant with, and prepared to discuss, not only medicine in all its departments, but all the collateral sciences. In other words, we are to wipe out of the minds of both friends and enemies any lingering doubt that we are still a group of therapeutic and materia medica specialists, and to stamp indelibly in its place that we are a school of medicine equal and abreast with any in the world.

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#### THE INSTITUTE AND MEDICAL EDUCATION.

No medical society, local or national, has done as much towards advancing the cause of medical education in America, as has the American Institute of Homœopathy. Of this we are proud; exceedingly so, in fact. The Committee on Medical Education, representing [the] great mass of the profession, working heart and

soul with the Intercollegiate Committee representing the college faculties, has been the means of accomplishing educational reforms that the American Medical Association with all its machinery has utterly failed to effect. Dr. Talbot, in presenting his report as chairman of the Intercollegiate Committee, congratulated the Institute on the reforms that had been effected. They were the following:

1. The requirements of a preliminary examination before matriculation.
2. The extending of the course of study and attendance upon lectures from two years to three years.
3. The extension of the lecture term from four or five months to not less than six months, and in some cases extending it to eight or nine months of continuous instruction in each year.
4. The establishment of a broader and more thorough curriculum of study.
5. The consideration—and by some colleges—the adoption of four years of medical study preparatory to graduation.

The Committee took occasion to make comments worthy of the thought of all physicians. It is certainly creditable in the highest degree to the gentlemen who are intrusted with the education of our students to learn that these reforms have been carried out by the united action of our thirteen colleges. We say, therefore, that those of our physicians who send their sons and students to allopathic colleges in order to give them a medical education should think long and well before taking such steps in future. We believe, with Dr. Talbot, that our colleges can and do give their students the best possible medical education attainable in the United States, and the sending of students to allopathic colleges by homœopathic physicians is an unmerited slight to our institutions.

Another point brought out by the Committee, and a good one it certainly is, was that many physicians are in the habit of sending their students, not to the best colleges, but to those at which they can get their tuition the cheapest and their diplomas with the greatest ease. As long as such a condition of affairs prevails there will always be miserably conducted colleges to supply the demand for cheap instruction and quickly gotten diplomas.

Thorough preliminary education is the key to efficient medical education. Be the student so thoroughly prepared as to pass the most searching examinations before college faculties or State examining boards, he cannot become a true physician unless he has



received a good general education. This the Intercollegiate Committee fully recognizes. It deplores the recent backward step taken by the New York State Legislature, a step that provides—using the Committee's own words—"that a student unfit to begin the study, of medicine, and who should consequently require a longer rather than a shorter term of medical study, may use one of his three years to make up deficiencies."

The importance of a standard of preliminary requirements for entrance was fully recognized by Dr. Talbot and his co-laborers, and we hail with delight the announcement of what would be expected of candidates for admission to our colleges on and after the fall of 1892. These were reported in full in our July number.

With all of our colleges fully alive to the cause, it was not surprising, though nevertheless pleasing, to hear Dr. Kinne, chairman of the Committee on Medical Education, announce that the occupation of his committee was gone. Still, the Institute acted wisely in continuing this Committee, for though there may be no duties for it at present, it is always a good principle "in times of peace to prepare for war."

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#### STILL AT HIS OLD TRICKS.

TWICE have we paid our respects to Dr. John Aulde, who, in making of alleged discoveries of new therapeutic agents, is far ahead of Ringer, Brunton, Phillips, *et al.* We would gladly let Dr. Aulde go without further notice, but his last utterances give evidence of such impudent assurance that we feel ourselves unable to remain silent.

It seems that his papers on the arsenite of copper have led to his being flooded with a stream of letters asking for instructions as to how to use the drug. He therefore proceeds to air himself in the *Medical World*. He announces the arsenite of copper as a remedy that he had been using for the past two years with marked success, as if that remedy had not been used by homœopathic physicians probably before Dr. Aulde ever thought of entering the practice of medicine. His good opinion of his own discoveries is furthermore shown by his remark to the effect that he hoped that those gentlemen who are doing *him* the honor of using the drug (just think of that for cheek), would conform exactly to his directions. Since we last heard from the Doctor, he has gone up a potency or so. He was for

a long time satisfied that one one-hundredth of a grain was the proper dose. But now he believes that one five-thousandth of a grain will give excellent results.

Another point worthy of note is the announcement by Dr. Aulde that a well-known pharmaceutical firm has prepared tablet triturates of the drug, triturates containing the hundredth and the five-thousandth of a grain each, and will supply the "regular (?) " physicians with samples should application be made for the same. We wonder why the preparations found in our homœopathic pharmacies would not do. We presume to use them would be a violation of the "code."

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#### DR. DAVID E. GARDINER.

DR. DAVID E. GARDINER, Philadelphia, died July 10th, after a six months' illness, the foundation of which was laid in an attack of the grippe last January.

Dr. Gardiner belonged to a family of physicians. His grandfather, Dr. William Gardiner, was the second medical apprentice and resident physician at the Pennsylvania Hospital, serving from 1786 to 1791, it being the custom at that time to receive as medical apprentices students of medicine, who usually graduated before leaving the hospital. His uncle, Dr. Richard Gardiner, with whom he studied medicine, was a well-known physician, and of his two cousins, sons of Dr. Richard Gardiner, William Gardiner, M.D., was formerly Dean of Hahnemann College, and Daniel Gardiner was a widely-known physician, who died at Woodbury a year ago, and another cousin, Dr. William H. Gardiner, now engaged in active practice, was formerly Assistant Demonstrator of Anatomy at the Hahnemann College, of this city. His son, Dr. William G. Gardiner, is a graduate of Hahnemann College of two years' standing.

Dr. Gardiner graduated from the Homœopathic Medical College in 1857, and after a few years passed in the practice of medicine at Manayunk, established himself at Bordentown, N. J., where he remained for twenty-one years and built up an extensive practice. About eleven years ago he returned to Philadelphia, and has since practiced in the same location continuously. He was fifty-six years of age. He leaves a widow, a son and three daughters.

## GLEANINGS

## GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

**ABNORMAL SENSATIONS OF TASTE IN SEXUAL NEURASTHENIA.**—Hypogeusia is to be defined as a lessened sensation of taste; an undefinable disgusting taste; a disgusting sweet taste; a burning sensation at the tip of the tongue; peculiar hallucinations of taste. One or the other of these may occur in association with pathological seminal losses.

Peyer observed a peculiar sensory neurosis of the tongue in a young pharmacist who in boyhood was addicted to masturbation, and who now suffered from frequent emissions. Since his seventeenth year he had been subject to sudden attacks of formication on the tongue, which at the same time becomes heavy. He was hardly able to move the organ, and while the attack lasted he could not make his speech understood. His lips may become similarly affected, as may occasionally other portions of the body.—*Wien. Med. Presse*, 20, 1890.

(We find foul disgusting taste under *arnica*, *causticum*, *mercurius*, *pulsatilla*, *sulphur*, in connection with sexual neurasthenia; a disgusting sweet taste under *belladonna*, *china*, *mercurius*, *phosphorus*, *plumbum*, *pulsatilla*, and others. A burning sensation at the tip of the tongue under *ammonium bromid.*, *baptisia*, *hamamelis*, *sanguinaria*, etc. Heavy tongue with formication under *anacardium*, *belladonna*, *calcareæ*, *carbo veg.*, *lycopodium*, *natrum mur.*, *plumbum*.—S. L.)

**TEST FOR IODOFORM POISONING.**—Dr. Burlureaux points out the reaction of saliva upon calomel as a means of diagnosing iodoform poisoning. A yellow iodide of mercury is produced which is easily recognized, the reaction being very sensitive.—*Journ. of Cut. and Gen.-Ur. Dis.*, July, 1890.

**THE ACTION OF KALI TELLURICUM AND ITS USE IN THE NIGHT SWEATS OF PHTHISICAL PATIENTS.**—Gmelin gave to a dog 3 grains of telluric acid and to a rabbit in three days 14 grains of tellurate of potash. The dog lost his appetite and vivacity; the rabbit was found dead on the fourth day. On opening the abdominal cavity of the latter a peculiar garlic-like odor could be perceived, the mucous membrane of the stomach and intestines loosened and covered with thick, tough mucus of a black color. Hansen gave dogs 0.3; only a minute afterward their breath had a garlicky odor; after twenty minutes they felt dull and vomited, and lost all appetite; the next day they recovered, but the breath retained the garlicky odor for some time. Increasing the dose to 0.7 gramme, the odor was still more pronounced, severe vomiting set in, and the feces became black. In another experiment he injected into the vena jugularis 0.5 gramme. There ensued twitchings, involuntary defecation, and, after four minutes, death. Autopsy revealed the strong, garlicky odor all through the intestines, which were black, as also the kidneys and other glands; the right ventricle of the venæ cordæ were full of blood; the urine was acid and of the same odor. Hansen took for seven days an hour before dinner: for four days, 0.04 kali tellur.; next two days, 0.05; the last day, 0.08. The first two days he complained of great sleepiness; at first increase and then loss of appetite. After last dose, oppression in cardiac region, nausea, copious salivation, white-coated tongue. The gastric symptoms disappeared after two weeks; the garlic odor kept up for seven weeks. Neusser gave kali tellur. in pills, 0.02 per dose, and succeeded in half of his phthisical cases in suppressing the night sweats; in other cases two pills were necessary to produce the same effect. It acted slightly as a narcotic, and in some cases it increased the appetite. All complained of the disagreeable odor.—*Wein. Klin. Wochenschr.*, 23, 1890.

**CUPRUM ARSENICOSUM IN ACUTE INTESTINAL DISEASES.**—Prof. Hugo Schulz has verified the indications for this drug in intestinal affections, but adds that it

must be given in small and frequently repeated doses to be effectual. In a case of Cholera Asiatica the daily dose is 0.0006, dissolved in 120.0-180.0 water, a teaspoonful at first every ten minutes, and then at longer intervals. Where water is contraindicated, Aulde, of Philadelphia, prescribes tablets containing  $\frac{1}{100}$  or even  $\frac{1}{250}$  of a grain. It succeeds best in fresh cases, before the inflammatory process extended to neighboring parts. It can abort severe cases of cholera and dysentery. Schulz thinks that the vital forces of the morbidly affected parts are stimulated by these small doses, and thus possess more resisting power to the morbid poison.—*Deutsch. Med. Wochenschrift*, 19, 1890. [Why not acknowledge the theft from homœopathic sources, as Buckner and Koeck, of Munich, were among the first to employ it according to the homœopathic law. Compare Lilienthal's *Therapeutica*, 3d edition, page 171, 302, 341.]

**THE MANAGEMENT OF OBSTINATE DROPSIES.**—Dr. James Tyson recommends in cases practically water-logged in the highest degree, where all the usual diuretics and purgatives have been used to no purpose, the use of skimmed milk at regular intervals and in fixed doses—two to eight ounces every two hours, together with the use of spartein in full doses, one-quarter of a grain three times a day, up to two grains daily. The milk is given skimmed because it is more easily assimilated. Dr. Tyson found that a diet of this character not only tended to reduce the dropsical accumulation, but it also greatly assisted the physiological action of such drugs as spartein and caffeine. This treatment is especially indicated in cases where there is a complete saturation of all the tissues, including the kidney itself, with transuded serum, and where there is no movement in the lymph spaces and lymph vessels.—*Medical News*, June 21, 1890.

**THE SWEAT-BANDS OF HATS.**—The sweat-bands of hats may contain even twenty-eight per cent. of fatty acids, which in summer may penetrate into the forehead and cause inflammation and deeply corrode the skin. To prevent this effect, it is advisable to rub the hat-band with burnt magnesia every little while, so as to leave a small film on the leather, wiping it off with a cloth before using again.—*Journ. of Cutan. and Genito-Urin. Dis.*

**HERNIA OF THE LUNG.**—Litten showed recently, before the Berlin Medical Society, a workman, who had suffered since 1869 from a pneumocele of the left side. The condition was not congenital, but acquired in a severe accident, by which four of the left ribs were broken. One could still recognize on the left side close to the sternum a large bone depression, from which, on cough or pressure, a large tumor protruded, disappearing inward in inspiration. In the immediate vicinity of the hernia there was no trace of the chest muscles—either pectorals or intercostals; besides the skin there was only the subcutaneous fatty tissue. The mass could be readily compressed and gave a crepitating sound. Acquired hernia of the lung is usually the effect of gun-shot injury. Most cases of pulmonary hernia, however, are congenital, and supposed to arise *in utero* from the elbow being pressed closely against the chest-wall, and so causing an opening, at the same time probably rupturing the fibres of the intercostal muscles, whilst the sac consists solely of the costal pleura.—*The Practitioner*.

**THE PNEUMONIA OF INFLUENZA.**—According to Leyden, pneumonia is the most frequent complication of influenza. It is still, he says, an open question as to the relation they bear to each other—whether the pneumonia is to be looked upon as a peculiar localization of influenza or simply a complication. He holds that at all events it is something more than a mere accidental complication, and that an intimate relation exists. Pneumonia has accompanied every influenza epidemic, and at each outbreak cases have occurred in exceptional numbers. As far back as Sydenham's time it was known that it differed from the ordinary form. Leyden points out as amongst its peculiarities, that its course was seldom that of typical pneumonia, that it rarely began with a decided rigor, and that the inflammatory symptoms—notably the pain in the side—were little marked. The local process likewise was not characteristic; one had frequently to seek for three or four days for local signs, then crepitation would be heard over a considerable area, and perhaps by the following day it had quite vanished, only to appear in another place. Not often did it come to hepatization with definite dullness. Typical rusty sputum was seldom observed. In many cases there was either no expectoration or it was catarrhal, perhaps, for

one or two days, of a sanguineous color. In single cases one saw a copious, serous expectoration, grayish white and often in great amount. The usual crises were seldom seen. In fact, the course of the inflammatory attack was altogether milder—the severe symptoms usually present, the urgent dyspnoea and the rapid infiltration, being all conspicuous by their absence; whilst the dangers were mostly conditioned by the state of the individual, the aged and enfeebled suffering most. The temperature chart likewise showed its favorable course. Further, the pneumonia spared no classes, the individuals who usually escape being affected in a degree rarely seen. A consideration of all these points of difference may raise the question whether we have to deal with a genuine pneumonia. This, however, is the case. Leyden suggests that in Berlin they had to do with several forms. He examined two cases *post-mortem*. They showed infiltration, and were designated fibrinous pneumonia, but the infiltration was loose and the section not granular but smooth; the condition appearing thus to differ from the usual fibrinous pneumonia. Microscopically, there was no firm hepatization from fibrinous masses, but a loose filling of the alveoli with cells having one or more nuclei.—*Berlin Klin. Wochenschr.*, No. 10, 1890.

**WARM, MOIST INHALATIONS IN PHTHISIS.**—The treatment of phthisis by inhalation of warm air, a method introduced by Krull, is that of allowing the patient to breathe air saturated with moisture and having a temperature a little above that of the body. The object is in no way to act upon the bacillus of tubercle (as in the hot air treatment), but to increase the power of resistance of the tissues. By means of the warm, moist air the bloodvessels which supply the lungs are dilated, the organs themselves more plentifully supplied with blood and the pulmonary nutrition increased. It is possible that in the affected lung the parts not yet invaded are made more resistant to the influence of the bacillus, while on the other hand absorption may be promoted in the diseased area and cicatrization induced. The results in Krull's hands are stated to have been very good. In a number of cases there was so-called "permanent recovery;" in others an improvement "almost approaching cure" was attained; whilst in some there was no result, and more especially was this the case in advanced forms or those complicated by syphilis or renal disease. The most convenient temperature for the air is 96.6° to 98.6° F., and the duration of the inhalation fifteen minutes daily.

Leubuscher brings forward sixteen carefully observed cases treated by this method. In four patients with advanced disease no improvement was apparent; in three there was almost "recovery;" while in the remaining nine more or less improvement was noted. The patients felt well both during and after the inhalation. No unfavorable symptoms arose, hæmoptysis never occurring, but on the contrary traces of blood disappeared from the sputum after inhalation.—*The Practitioner*.

**PNEUMONIA AND PREGNANCY.**—L'Union Fraigniaud, in the *L'Union Médicale*, states: Although the occurrence of pneumonia during pregnancy is a by no means rare accident, its history is still incomplete; certain points require elucidation. Pneumonia is known to be a grave complication of pregnancy, and in the majority of cases to bring about its interruption; the nearer the pregnancy approaches its termination the more probable is the expulsion of the fœtus, and the more serious is the prognosis for both mother and child. It is not known, however, what is the influence, good or bad, exercised by abortion or premature labor upon the progress of the pneumonia, whether the mother benefits or suffers by the interruption of pregnancy, and, consequently, in our practice, whether it is right to encourage or prevent miscarriage. Some authors consider that expulsion of the fœtus favors resolution of the pulmonary lesion, and consequently advise active interference to empty the uterus; other authors hold that most often the woman succumbs after abortion, and consequently advise that all possible means should be used to prevent it.

Fraigniaud relates the case of a primipara, aged 21, in whom, already weakened by repeated ailments during her pregnancy, pneumonia supervened at the end of the eighth month.

In spite of the usual treatment (kermes, mineral, quinine, brandy, tincture of iodine applications), the condition of the patient became steadily worse until, on the evening of the sixth day, labor commenced. This went on easily, a living child, healthy but very ill-nourished, being born on the morning of the seventh day. Consequent upon this there was an immediate improvement in the maternal condition. Fraig-

niaud is of the opinion that when pneumonia occurs at the end of pregnancy, premature labor is to be looked upon as a fortunate event, and that in special circumstances an active interference is to be recommended.—*The Medical Chronicle*.

**THE CAUSES OF PERNICIOUS ANÆMIA.**—Writing on the subject of pernicious anemia, M. Müller describes a case in which the bothriocephalus latus appeared to have set up this disease. The diagnosis of pernicious anemia was established by the presence of fever, by retinal hæmorrhages, and by the characters of the blood. The blood was very watery; and the red corpuscles, whilst their color was relatively preserved, presented some large nucleated forms. The writer also gives an account of four cases of pernicious anemia in which syphilis was present. He contends that in two cases syphilis actually bore a causal relation to the disease of the blood, specific treatment proving very successful. It is manifestly necessary to accept M. Müller's conclusion with great caution, the connection of the pernicious anemia with the other diseases named being open to a different interpretation.—*The Practitioner*.

**TREATMENT OF COCAINISM.**—Dr. T. S. Clouston, Lecturer on Mental Diseases in the Edinburgh University, thus summarizes the salient facts about cocaine in relation to cocaineism: It is the acutest and most absolute destroyer of inhibition and of the moral sense generally yet known. The morbid craving is very intense and control is absent. To get the same effect, the dose requires to be increased faster than that of any such drug. Its immediate effects are more transient than other allied drugs, but this does not apply to the craving set up. Cases have been recorded where the drug, from being used in the most legitimate way, as an external application to subdue the pains caused by skin eruptions and sores, has set up a craving for its continuous use and for its effects on the higher brain functions quite apart from the analgesic effect for which it was employed.

The treatment of cocaineism consists in outside control of the patient, in at once stopping the drug, in careful watching, nursing, the use of every sort of food that will keep up the strength, and of the bromide of ammonium, brandy or wine, tea and coffee, and possibly a hypnotic, like paraldehyde or sulphonal, for at least two or three nights.—*The Practitioner*.

**A FLOATING SPLEEN IN THE PELVIS.**—Dr. Klein, of Breslau, has described, in the *Münchener Med. Wochenschrift*, a case where a large displaced spleen was found, during a necropsy, in the pelvis of a woman aged 63. It lay in the utero-vesical pouch, the uterus being pushed far backward. Between the spleen and the greater curvature of the stomach ran a cord of the thickness of a man's thumb, twisted once on its long axis. This cord was formed out of the suspensory ligament of the spleen and the gastro-splenic omentum. The weight of the displaced organ seemed to account for its descent into the pelvis; the traction on the long cord had drawn somewhat downward the stomach, liver and transverse colon. A ring pessary was discovered in the vagina, where it had apparently lain for some time; this suggested that the spleen might have been mistaken for a retroverted uterus, as already occurred in a case described by Diehl and Rezek. Perfect evidence of such an error, however, could not be obtained, as the introducer of the pessary could not be traced. The instrument might have been slipped in on empiric grounds to relieve symptoms of bearing down without any accurate exploration, and on the other hand, the displacement of the uterus backward may have been diagnosed and the pessary applied with a view to support that organ.—*British Medical Journal*.

**TACHYCARDIA AND BRADYCARDIA.**—Dr. Groedel, Manheim, says: "More than half of the persons complaining of cardiac palpitations are free from all valvular troubles, and only suffer from disturbances of innervation of the heart. Murmurs without any organic alterations may be heard only in cases of chlorosis or anemia. Such nervous palpitations are often witnessed in persons of a neuroasthenic habit, from heredity, and then any depressing effect, gynecological diseases, climaxis, disturbances in the digestive organs, especially flatulency and habitual constipation, intoxications from the abuse of tobacco, tea, coffee, etc., or arthritis may set the ball in motion. Often regulation of the mode of life and sensible hydro-therapeutic treatment with a sojourn where pure fresh air can be enjoyed, suffice to quiet this nervous excitement without any medicinal treatment, though iron, arsenic, quinine are said to act beneficially. In tachycardia, on the contrary, we meet a considerable and continued acceleration of the action of the heart without any subjective sensation of palpitation, which may be permanent or come in paroxysms; the heart is

also here mostly intact; even where there is a cardiac difficulty, it can often only be considered as a predisposing excitant for the paroxysms. Leyden considers tachycardia as a state where the vagus is paralyzed or threatened with paralysis. Gerhardt also considers paralysis of the vagus the cause of most nervous tachycardia and those where the pulse rises above two hundred, arise from a combination of paralysis of the vagus with irritation of the sympathetics. Bradycardia, a retardation of the pulse, may also be caused by disturbances of innervation, and may be seen in persons enjoying otherwise good health, or it may be a symptom of some other disease, as of arterio-sclerosis, especially of the coronary arteries or of fatty heart; or it may arise from acute articular rheumatism without any cardiac disease; or it may be associated with coprostasis, icterus, convalescence from acute febrile diseases, affections of nervous central organs or of peripheral nerves, and chronic infections and constitutional diseases."—*Berliner Klin. Wochenschr.*, 21, 1890.

## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

**THE TREATMENT OF CICATRICES OF THE VAGINA.**—Otto Küstner reports an interesting case of extreme stenosis of the vagina, the result of sloughing after labor, in which the usual treatment of dilatation and incision failed. He then dissected out a large portion of the cicatrix and replaced the extensive defect caused by this operation with a piece of human intestine, which had just been removed in an operation for an artificial anus and had been preserved in a warm six per cent. chloride of sodium solution. The wound healed perfectly and the intestine united at every point. Not enough of the cicatrix had been removed and a second similar operation was performed higher up in the vagina, a piece of mucons membrane from an old vaginal prolapse being used for the new flap of tissue. The result was not good, and a few months later cicatricial tissue was again dissected away and the surface covered by a flap taken up from the vagina, turned at an angle of 90° and united over the wound. The raw surface left bare was covered by iodoform gauze and healed by granulation.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd. xviii., H. 2, 1890. (This flap operation is somewhat similar to the operation of B. Crede, who replaced the loss of substance in the vagina by a flap from the labium majus. The objection to this operation is the growth of hair in the vagina.—G. R. S.)

**THE TREATMENT OF ENDOCERVICITIS.**—Stratz made a series of observations to test the value of the application of chloride of zinc and lactic acid. He found the former was the better of the two applications. Scarcely any benefit was obtained from weak solutions. A 50 per cent. solution of chloride of zinc cured some cases and also seemed to produce cicatricial hardening of the tissue. The leucorrhœa returned after a few months in nearly all cases. He considers Schröder's excision far superior for the treatment of such cases. He also made a series of careful microscopic examinations to test the comparative frequency of endometritis and endocervicitis. In thirty well-marked cases of the latter disease with slimy, purulent discharge, there were only five showing signs of endometritis, three of the interstitial form and two in which the glands were chiefly involved.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd. xviii., H. 2, 1890.

**THE TRUE CORPUS LUTEUM.**—Dr. Gottschalk exhibited to the Berlin Obstetrical and Gynecological Society, two large corpus luteum cysts, one the size of an orange and the other the size of a small apple. The chief points of interest are the extreme size of the cysts and the fact that they were found in a sterile woman. In other words, a large corpus luteum is not necessarily dependent on pregnancy or absolute proof of it, as has been generally considered.

**CONTRIBUTION TO THE QUESTION OF STERILITY.**—In an excellent article on this subject, Drs. Lier and Ascher are of the opinion that in a large proportion of cases, the husband is to blame rather than the wife, and recommend a microscopic

examination of the semen and an inquiry as to the previous existence of gonorrhœa or any of its consequences.

Among 76 women applying for treatment for absolute sterility, 16 were perfectly normal, 29 showed slight obstruction to conception, and in 31 the mechanical obstruction was marked; and in 15 of these there was gonorrhœal endometritis, salpingitis or perimetritis. The cases belonged to the higher and middle classes of society. Among the 76 husbands, 15 denied examination and 15 were absent. 46 were examined; 21 of these were azoospermikers, 2 were oligozoospermikers, 5 of the men had severely infected their wives with gonorrhœa, 6 were impotent and 5 partially so. In other words, in 70 per cent. of these cases (46-32) the primary fault was with the husband.

Even with years of careful treatment, those women suffering from chronic gonorrhœa were seldom cured so as to conceive. There were only 4 women among the 41 infected who became pregnant after treatment. They found 28.9 per cent. of the husbands sterile (azoospermikers); 11.8 per cent. sterile as the result of gonorrhœa and 9.2 per cent from impotence or sexual excess, i.e., in 49.9 per cent, marriage was unfruitful on account of the men.

In another summary of 151 cases of sterility complicated with other diseases: In 79 of them, gonorrhœal infection was the cause of it. 86 of the husbands were examined; 21 of these were azoospermikers and 2 were oligozoospermikers. Of the 60 vigorous men, 34 had certainly infected their wives with gonorrhœa at the beginning of married life. In other words, 30 per cent. of the men were sterile and 39.5 per cent. of the remainder had made their wives so by infection, i.e., about 70 per cent. of the men were to blame for the sterility of their wives. It may be said here that the azoospermism was mostly due to gonorrhœa.

Twenty-five of the wives of the 35 men who refused to be examined had gonorrhœa in some form. None of the wives of these men became pregnant after treatment, and only 17 of the entire 151 women conceived. 131 women had married 15 azoospermikers, 70 men infected with gonorrhœa and 2 were married to impotent men; or 87 men who were in fault. Only 4 of these were cured. On a summary of these 151 cases, 26 men were sterile (21 azoospermikers, 5 impotent), 17.2 per cent.; 70 men (not including the above) had caused sterility by gonorrhœa, 46.4 per cent.; 30 women were probably, but not with absolute certainty, sterile; 25 cases are not to be decided as to who is at fault. Very few of the entire 227 cases were cured when gonorrhœa was present, and it may be said with the greatest probability, that in 66½ per cent. of all cases, sterility is due to the male rather than to the female.

In 22 more cases where they were consulted for relative sterility, i.e., having given birth to one child but not becoming pregnant after a considerable period of time, they found gonorrhœal infection had taken place soon after childbirth in a large proportion of cases. No case recovered, i.e., became impregnated, in spite of long-continued treatment.

In another series of 175 cases of sterility which consulted them for other complaints than sterility, inflammation of the uterus or appendages and the remains of a former inflammation of the peritoneum and cellular tissue as well as the history of a former puerperal fever were apparently common causes of sterility. Gonorrhœal infection was also observed. No cases were included where means were taken to prevent conception. Indeed, many of the women stated that they had formerly employed preventive measures and given it up as they felt so much better without the prevention.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd., xviii., H. 2, 1890.

**PYOSALPINX AND THE GONOCOCCUS.**—Von Rosthorn reports that, in twelve cases of pyosalpinx, of undoubted gonorrhœal origin, a careful search for gonococci, both by culture and direct examination, was in vain. He agrees with Bumm and Fränkel, that the presence of the gonococcus in chronic cases is too uncertain to be considered reliable and practical proof of the origin of the disease. In about half the cases of salpingitis severe menorrhagia and atypical hæmorrhages were present. Persistent colicky pains were present in nearly one-fourth of the cases. Perimetritis was present to an equal extent.

In difficult cases, the end of the tube next to the uterus was first divided and then the mass carefully enucleated, splitting the broad ligament, if necessary, to remove the diseased tube. In some cases the pus sack ruptured and the contents escaped. The peritoneum was cleansed with a 2½ per cent. solution of carbolic



acid. In no case did infection follow such a discharge of pus, even when it was offensive. It may, therefore, be assumed that in chronic suppuration of the Fallopian tubes or abscess-cavities proper, the pus gradually loses its virulence.—Gusserow, Hegar, Kaltenbach, *Archiv. für Gynäkologie*, H. 3, 1890.

**THE OPERATIVE TREATMENT OF UTERINE MYOMATA.**—In four hundred cases of myoma Leopold found 81 per cent. occurred in married women. He attaches much importance to the copious lymphatic discharges which weaken the patient nearly as much as hæmorrhages. He urges the importance of an early operation before the patient's strength deteriorates and draws particular attention to degeneration of the heart-muscle as a contra-indication to operating. Dilatation of the cervix, with laminaria tenta, has been very beneficial in controlling uterine hæmorrhage. Castration has given excellent results, nearly all the tumors disappearing or diminishing. Vaginal hysterectomy is recommended in preference when practicable. The growth must not be larger than an infant's head if this operation is to be performed. In myomectomy he prefers the extra-peritoneal method rather than the intra-peritoneal. His rate of mortality for myomectomy is 21.2 per cent.—*Archiv für Gynäkologie*, Bd. xxxviii., H. I., p. 1, 1890.

**INVERSION OF THE UTERUS.**—Barsoni, of Budapest, reports a case in which a midwife removed a placenta by main force. Unconsciousness followed. For four weeks the woman suffered from puerperal fever, continual hæmorrhage and pain. When she tried to exert herself she felt a swelling the size of an egg about the labia. Three months afterwards Baselli was called in. Reposition with the hand and with the colpeurynter was tried many times, but unsuccessfully. Removal of the uterus was being seriously considered, when, as a last experiment, reposition with the patient in the knee-elbow position was tried, and succeeded in restoring the organ to its normal position.—*Wien. Med. Presse*, 15, 1890.

**AGALACTIA.**—Dr. Messinger has used the following treatment successfully in cases of agalactia: Daily massage of the mammary glands; aloes in divided doses; cold sponging and friction of the mammae morning and evening. After the third application of the massage, he noticed a bluish network of vessels on the anterior surface of the thorax. After the sixth, milk could be pressed out from the nipples, and after the sixteenth the flow of milk was usually fully established. The massage was applied by carefully stroking the gland from the nipple centrifugally in all directions, with a fine foam of soap in order to evacuate the veins, the masseur standing at the head of the patient. The anæmia thus occasioned is followed by an arterial congestion, and the vitality of the mammary glands is increased. A good result may be expected in three-fourths of the cases.—*Wien. Med. Presse*, 16, 1890.

**SYPHILITIC AFFECTIONS OF THE UTERUS.**—Mr. Henry Lee reports two cases that may safely be looked upon as syphilitic uterine affections. The first one was that of the wife of a man who had had syphilis. She herself had a distinct syphilitic eruption of the lower part of the body. She had been under a prolonged course of treatment for disease of the womb, and for weeks together had kept to her bed on account of menorrhagia. After a sustained course of mercury she was perfectly cured. The other case was that of a woman with syphilitic eruptions, who suffered from backache, bearing down sensations, and almost constant leucorrhœa. Any pressure in the neighborhood of the uterus gave rise to pain. Under a mild course of mercury all her symptoms disappeared.—*The Lancet*, July 5, 1890.

**THE HOT WET PACK IN THE TREATMENT OF ECLAMPSIA.**—Dr. Barton Cooke Hirst looks upon the hot wet pack as a most valuable agent in the treatment of puerperal eclampsia. Cases apparently hopeless under other methods of treatment oftentimes yield to the profuse diaphoresis following a hot wet pack. The pack is to be given by wringing out four blankets in hot water, surrounding each lower extremity, the trunk under the arms, and finally the trunk and arms with the hot, moist blanket, first slipping under the patient a rubber sheet, and afterwards tucking a couple of dry blankets over the whole, the head being kept cool by cloths dipped in ice-water. The sweating thus induced was profuse, and no doubt carried off the greater part of the poison in the blood. The hot wet pack treatment Dr. Hirst thinks preferable to any other. Chloral and bromide of potassium, which lessen muscular action and dull sensibility, can be but temporary makeshifts until the more important object of treatment is obtained.—*University Medical Journal*, July, 1890.

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**PATHOLOGY AND NEW TREATMENT OF SYMPATHETIC OPHTHALMIA.**—The conclusions of Leber and Deutschmann in regard to the pathology of sympathetic ophthalmia, as presented by Dr. Charles Abadie, of Paris, are that genuine sympathetic ophthalmia, resulting from a traumatic lesion, is a formidable microbian disease, of infectious origin, causing sympathetic irritation through the transmission of the infection by continuity of tissue through the optic nerve and chiasm to the opposite eye. This seems more reasonable than that the irritation is transmitted through the ciliary nerves and nervous centres. The therapeutic agents and dressings applied to the injured eye may not be antiseptic; the edges of the wound may not lie down closely or evenly, and it thus becomes invaded by microbes. These soon generate and multiply, penetrating into the deeper parts of the eye, and through the chiasm into the optic nerve of the opposite side. Thus we have an easy explanation of the chain of pathological phenomena during the evolution of microbes and their disorganizing action upon the healthy tissues. These same ideas seem to explain the remaining obscure points in the progress and treatment of this singular and formidable disease.

The present prominent method of treatment is enucleation of the injured eye in order to save the second eye. It is evident that if enucleation of the infected or injured eye is performed before the infection has gained access to the optic nerve, and thus the means of communication cut off by section of the nerve, the propagation is cut short and the other eye saved.

Saving the good eye will be assisted, besides enucleation of the bad eye, by the use of mercurial germicides (general ointment injections). This is one method, but at present, as we have a better knowledge of the true nature of the disease with which we have to combat, we should, and we can, give much better and more effective treatment.

We are now told that enucleation may be avoided, even where an eye is seriously injured. At first, we try by a strict antiseptic treatment to avoid all infection, but if, in spite of all, infection occurs, we cauterize the wound with the cautery point, wherever it may be, being careful to apply it to every part of the wound, and to have the patient thoroughly chloroformed. Notwithstanding all this, if it should develop, try to prevent its further progress by injecting into the eye (which now seems destined to enucleation) one or two drops, at most, of a 1 to 1000 bichloride solution. These injections cause considerable irritation for some hours, but little by little the reaction subsides, until the eye becomes normal, and both eyes then improve. Abadie then cites three cases in which he injected the bichloride solution—in one case two drops of a 1 to 500 solution—all of which were followed, in a few days, by complete subsidence of the inflammation and all irritation, and finally by considerable acuteness of vision. In view of these facts he says, that enucleation, heretofore the first thing to be done, should only be resorted to at once, in those exceptional cases where there is absolutely no hope of saving the eye.—*American Journal of Ophthalmology*, June, 1890.

**TREATMENT FOR THE RADICAL CURE OF POLYPI OF THE NOSE.**—Dr. E. Harrison Griffin, of New York, after the use of caustics and irritants—chromic, glacial, acetic, carbolic, tannic acids, the actual cautery, and the tincture of iodine—upon the nasal mucous membrane after the removal of polypi, finds that these growths return more quickly when their removal is followed by the application of irritants. He operates with the snare in preference to all other methods, first putting the parts under the complete control of cocaine. This he considers a most important part of the operation: first, the cocaine empties the bloodvessels of the turbinated tissue and allows a more nearly perfect view of the growths; and second, because, when the part is under the influence of the drug, the hæmorrhage is more perfectly controlled and the irritation resulting from the introduction of the snare greatly diminished. In removing these growths the aim should be to produce as

little irritation as possible, and after the operation the same condition of affairs should still be preserved.

Any irritation will lead to a recurrence of these growths, as proved in the practice of Dr. Griffin, who was therefore led to abandon all medication with the exception of witch-hazel or the application of pure alcohol. To the former he gives the preference, instructing the patient to spray the nose night and morning with this drug, by means of a Burgess spray, diluted at the start with water and gradually increased to full strength. The parts should be thoroughly moistened with the drug, so that it floods the nasal fossæ and runs into the lower pharynx. This treatment should be persisted in for at least a year after the last remaining polypus has been removed. The nose should be examined at stated intervals and if there is a semblance of a polypus it should be removed. With this treatment the majority of cases can be permanently cured and the rest greatly relieved.—*Medical Record*, June 28, 1890.

**TRICHLORACETIC ACID IN INTRA-NASAL DISEASES**—Though the galvanocautery has to a great extent supplanted chemical agents in the treatment of hypertrophic rhinitis, in many cases the cicatrix produced by the application of pure chromic acid is sufficient to cause contraction of the turbinated bodies, and possesses the advantages of not alarming the patient and of requiring comparatively little manipulative skill. Its disadvantages are that unless considerable care is exercised the acid spreads, causes an unnecessarily large slough, and an undesirable amount of inflammatory reaction.

Trichloroacetic acid, recently introduced in Germany as a cauterant, apparently has all the advantages and none of the disadvantages of chromic acid. Von Stein and Stanislaw, of Moscow, *Journal of Laryngology and Rhinology*, June, 1890, recommend it not only in the treatment of hypertrophy but in that of acute nasal catarrh (coryza), ozena, adenoid vegetations, and of various laryngeal diseases. Making due allowance for the enthusiasm of the experimentalists, their assertions are still so positive that the drug should be given a fair trial, although we believe its field will eventually be restricted to the cauterization of hypertrophies and possibly as a stimulant in the treatment of ozena.

As a cauterant a crystal of the pure acid should be applied by means of a probe, precisely as chromic acid is ordinarily used, and, of course, during cocaine anesthesia. In ozena a weak solution (five-tenths of one per cent.) should be rapidly brushed over the diseased mucous membrane. It is stated that this treatment, if repeated daily, corrects fœtor, softens the crusts and prevents their formation.—*Medical News*, June 5, 1890.

**TORTICOLIS SIMULATED BY OCULAR DEFECT**.—During November, 1887, a young woman of seventeen years presented herself at the clinic of Dr. E. M. Landolt, accompanied by her parents, who said that their daughter suffered from her present trouble since early childhood. The head was strongly flexed upon the shoulder and the face turned towards the opposite side. The vertebral column had also taken a compensatory curvature, and presented a marked convexity towards the left in its upper part, towards the right in its inferior part. Every attempt to restore the head to its normal position was irksome to her. Left to itself it immediately returned to its abnormal position. Physicians and surgeons treated her without the least result; electricity, baths, orthopædic measures and internal treatment failed, and as she grew taller the wry-neck seemed only to increase. Patient and parents refused operative measures. As she never had complained of her sight (she was emmetropic) the family physician requested them to go to an oculist to find out whether the eyes, which play such an important part in the position of the body, were not to blame for this obstinate torticollis. It sufficed to put a colored glass over one of her eyes and to look at the flame of a candle held at the other extremity of the room. In the habitual position of the head the light was seen simply binocular, that is, slightly colored. But when the head was put in its normal position the flame appeared double, and this diplopia was absolutely characteristic of a paresis of the superior oblique of the left eye. In fact, this eye looked as if standing higher than the other and slightly convergent, and the objects looked at appeared necessarily lower and situated to the left side. To prevent this diplopia she was forced to incline her head towards the right shoulder, and the face in the opposite direction, hence the false position which simulated a torticollis. Only an operation can cure such a long-standing paresis.—*Bulletin Méd.*, 50, 1890.

**THE RELATION OF DISEASED CONDITIONS IN THE UPPER AIR PASSAGES TO SO-CALLED NASAL REFLEXES.**—Dr. F. H. Bosworth, of New York, speaking of the large number of diseases now recorded in the category of nasal reflexes, believes the direct cause not to be in the nose. As to the question of hay fever and asthma, intranasal disease is not the cause of every case of these two diseases. The special morbid lesion which gives rise to a paroxysm of perennial asthma is a dilatation of the bloodvessels which circulate in the mucous membrane lining the bronchial tubes, the result of vaso-motor paresis. Again, there are two predisposing causes of asthma: First, that condition of the general system which we call neurosis, under the influence of which an individual becomes liable to vaso-motor disturbances in one part of the body or another. Second, a chronic inflammatory process involving some portion of the upper air-tract. In chronic inflammation the prominent feature is vascular dilatation, and the whole mucous membrane of the upper air-tract is closely and intimately related. A hyperæmia of the bloodvessels of the nose shows a marked tendency to be followed by a similar condition of the mucous membrane of the bronchial tubes. Asthma, as before remarked, is not in all cases caused by an intranasal condition, but an intranasal morbid condition plays an exceedingly important part in its development. In the author's original paper—*Asthma, with an Analysis of Eighty Cases*—forty-six were reported as cured and twenty-six improved, the treatment being largely intranasal. In view of these figures and the chief method of treatment, there can be no doubt but that a large majority of cases, if not all, are dependent upon an intranasal lesion, and the two affections are so closely related that the asthma can be materially affected and controlled by medication to the nose. As regards hay fever, this is considered as practically one and the same disease with asthma, and is to be treated in the same way.

In regard to certain nervous diseases, such as epilepsy, Dr. Bosworth said he had seen nothing in his own practice which warranted the belief that that disease is a nasal reflex. An intranasal condition may be a source of marked irritation, the removal of which will modify the symptoms of nervous troubles, but that epilepsy has ever been cured by intranasal treatment is exceedingly doubtful. Of chorea, he has known of only three cases that have been sufficiently long under treatment to warrant the statement that they have been permanently relieved by intranasal treatment. The good results in these cases can be explained by the fact that the removal of the morbid conditions in the air-passages of young patients is often followed by marked improvement in the general health.—*New York Medical Journal*, July 5, 1890.

**FOREIGN BODY RETAINED IN THE NOSE FOR TWENTY FIVE YEARS.**—Dr. Major, of Montreal, reports the case of an English woman recently arrived in Canada, who had applied at his clinic for diseases of the nose and throat at the Montreal General Hospital for relief from nasal obstruction. The patient attributed the difficulty she experienced in breathing to a catarrhal condition, the result of climatic causes. On examination, the right nostril was seen to be occluded by swelling of the turbinated tissue, but when a probe was passed for exploratory purposes, a foreign body of large proportions was encountered.

Cocaine was applied, and, with difficulty, a rhinolith was dislodged which was drawn through the nostril after some trouble. The body measured 19 by 13 by 9 millimetres, and weighed, when removed, two grammes and a half. The patient, who gave her age as thirty-one years, stated that when six years old she had introduced a number of small sea shells into the nostril. She had always believed that they had all been removed. She thought it quite likely that a shell would be found to be the nucleus of the mass. The woman's husband, who accompanied her, said he remembered perfectly the sea-shell episode and could of his own knowledge confirm his wife's statement. The rhinolith, intact, was produced, and, when it was crushed, fragments of a pearly nature were easily distinguished. It is an interesting fact that a foreign body can occupy a nasal chamber for twenty-five years without exciting suspicion and without giving rise to much annoyance. It was also curious that when examining the patient no offensive odor was detected and the lip was not excoriated, as is usual in such cases.—*New York Medical Journal*, June 28, 1890.

## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

**RADICAL CURE OF HERNIA.**—In the enthusiasm resulting from the immunity given by antiseptic measures in the cutting operations for hernia, methods have multiplied, and so-called “cures” have been reported at too early a date. Bull contributes a valuable article on this subject (*Medical News*, July 5, 1890), and suggests that the word “cure” be discarded, and the comparative value of methods be estimated by the result as to recovery, wound complications and healing, and then by the proportion of relapses in those that can be seen and examined at remote periods. He presents his experience of seven years, and divides his cases into four series: (1.) Forty cases treated by “ligature and excision of the sac” (Socin). The canal was split and the sac was ligated at its highest point (Riesel) with catgut, the portion below excised when small, and simply drained through the bottom of the scrotum when large or containing the testicle. (2.) Thirty-nine cases treated by “ligature, excision and suture” (Czerny, Banks). The steps are the same as the above plus suture of the pillars of the external ring and the aponeurosis with catgut. (3.) Thirty-nine cases treated like the last, except that the anterior wall of the canal was not divided when it was possible to reach the neck by drawing down the sac. The canal was sutured by two layers of silk or gut, the deeper uniting the muscular fibres, the other the aponeurosis and pillars. This he calls “ligature, excision and suture of the canal.” (4.) Sixteen operations on children (four to fourteen years of age), no one method being followed. These are recent, having been operated on within six months. The total of one hundred and thirty-four cases are considered with reference to indications, mortality, complications and wound results. As to indications, seventy-seven were reducible, forty-two irreducible and fifteen strangulated. Irreducible cases should always be operated on and a radical cure attempted, except large old scrotal enteroceles, in which extensive and firm adhesions will make replacement difficult and dangerous. In strangulated hernia the radical operation should be added unless the condition of the patient or gut contraindicate it. The reducible cases presented difficulties in the management of the truss, or desired the operation. As to age, radical cure had best not be attempted above fifty years, unless the hernia be irreducible or strangulated. In children, difficulty of retention, failure to bring about improvement or irreducibility were the indications for operation. As to the mortality, there were three deaths: two non-strangulated from hæmorrhage of the omental stump, and the third strangulated from shock. They were old and feeble patients. The complications were, hydrocele three times, which was simultaneously treated; division of the vas deferens, followed by suppuration of the testicle; wounds of the intestines, four times, successfully treated by suture. Primary union took place in about one-half the cases, but suppuration, when present, was usually slight, and confined to slowly-healing drainage sinuses. Erysipelas occurred once. Moist bichloride dressings, rubber drains and Kocher's catgut were used. Buried sutures of silk gave rise to abscesses, and were discharged in every instance. As to results, twenty-two out of the forty cases in series I. were traced, in whom there were about 38 per cent. of relapses. In series II. there were 40 per cent. of relapses, while in III. these amounted to over 50 per cent. As most relapses occur during the first year, it is interesting to note that the ratios were as follows: I., 27 per cent.; II., 40 per cent.; III., 42 per cent. The children's series shows one thing, that when the sac was not found, simple suture of the rings was followed by a prompt recurrence. The author is in favor of a light support after the operation, but deprecates any strong pressure upon the recently healed parts. He is skeptical as to the possibility of a radical cure in any form of hernia, as the majority relapse sooner or later. He believes that the attempt should be made as the patient's condition is bettered, when the rupture is irreducible, or mechanical treatment difficult or painful. As a result of his experience, he will use the simplest method (series I.), that of ligating and excising the sac, which, besides, is applicable to all forms of hernia.

**TREATMENT OF STRANGULATED HERNIA.**—Benjamin Walker reports two cases of strangulated hernia, the one inguinal and the other umbilical, which were re-

duced spontaneously by the use of hyoscyamine and ice. The former, he thinks, acts by relieving involuntary muscular spasm, and the latter by contracting the bloodvessels (as does the ether spray—Eds.) In one case, half a milligramme of hyoscyamine was administered every half hour for about fifteen hours. An equal dose of sulphate of strychnia was given with it, and a bag of ice and salt applied to the tumor. In the other case the same drug and dose was used every fifteen minutes. Hydrochlorate of morphia was administered too, but no ice was applied. Relief was obtained in three hours. Eight months later, however, the hernia became strangulated again, the remedies failed and the patient succumbed to the operation! It is not stated how much valuable time was lost in the hyoscyamine and ice treatment, but the author, while extolling this treatment, admits that it is dangerous if there is a suspicion of gangrene.—*London Lancet*, July 5, 1890.

**SUBCUTICULAR SUTURES.**—To obviate the white scar points left on each side of a wound, that may have so healed by first intention as to make a scarcely visible cicatricial line, Kendal Franks proposes to use a continuous buried suture to close wounds. He takes a small curved Hagedorn needle threaded with the finest catgut and, beginning a quarter of an inch from the upper angle of the wound, passes it horizontally along the cutis vera to the extreme angle of the wound. Emerging, it is re-entered on the other side and brought out opposite the first point of entrance. The catgut is drawn through, leaving enough at the point of entrance to tie with the portion attached to the needle. The needle is then inserted just below the first point of entrance and brought out a little farther down, reinserted directly opposite and carried a corresponding distance, and so on until the other angle is reached, forming, by its visible portions, the rounds of a ladder. It is drawn taut, a knot tied in the end and buried (or, I have found it convenient to tie the gut to one end of a knotted loop like the one used to begin the suture.—W. B. V. L.)—*British Medical Journal*, February 22, 1890.

This method does not differ essentially from those recommended by Marcy and Halstead. The former uses a subcutaneous cobbler's stitch of kangaroo tendon or catgut, with a needle at both ends, or one with the eye in the point. By drawing on the ends, the wound is tightly closed; they are then tied and the knot buried. Halstead, who prefers silk to catgut, found, in his experiments with dogs, that the silk stitches frequently produced suppuration. Attributing this to infection from the sebaceous glands, he closes his wounds by a subcutaneous suture, and finds that the silk causes no further trouble.

**PROTECTIVE TO DRAIN WOUNDS**—Fessler, Nussbaum's assistant, has been using Lister protective instead of large drainage-tubes for the last two years. It is kept in bichloride solution, 1 to 1000, and cut into strips several centimetres in width and of suitable length. Before closing the wound a strip is carried to the deepest portion, the end being allowed to protrude a little. The wound can be tightly united around it and the discharges readily run out over its smooth surface; it takes but little room, and air cannot consequently get in as through a drain.—*Münchener Medic, Wochenschrift*, 1890.

**SYSOL AS AN ANTISEPTIC.**—Gerlach, of Wiesbaden, has recently used the above with good results. It is more powerful as a bactericide and less poisonous than either carbolic acid or creolin. Its use should not be confined to closets, stools, etc., but it may be employed generally throughout the domain of medicine. The active principle of sysol is cresole. The author believes the drug to be of real value, and that it will come into general use.—*Medical Record*, July 5, 1890.

**A NEW LOCAL ANÆSTHETIC.**—Dobisch recommends a new method for producing local anæsthesia. He uses a Richardson ether spray apparatus with ten parts of chloroform, fifteen parts of sulphuric ether and one part of menthol. One minute's application produces complete insensibility, which lasts from two to six minutes. He has operated with gratifying results, both as to anæsthesia and wound healing, in cervical abscesses, felons, and epithelioma of the nose.—*The Lancet*, June 14, 1890.

**DEATH FROM HYDROBROMIC ETHER.**—A dentist anæsthetized a healthy youth of seventeen with twenty-five grammes of hydrobromic ether, to which he added five or six drops of chloroform to increase the narcosis. The patient walked home but complained of heaviness in the limbs, which continued after a good sleep. This was

followed by pains in the back, chilliness, malaise, gastralgia and dyspnea. Dover's powders gave some relief, but extensive chest râles the following evening so alarmed his family that a physician was called in. In spite of ether hypodermatically (!) he soon died. The autopsy revealed nothing.—*Bulletin Medical*, No. 48, 1890.

**ACUTE PERITONITIS FROM GONORRHOEA.**—C. B. Penrose contributes a rather unique observation bearing on the much discussed question of gonorrhoeal peritonitis in women. As a rule the course is a slow one, *i.e.*, salpingitis, closure of the fimbriated end, distension and chronic peritonitis by gradual leakage, or direct extension, or acute peritonitis from rupture. Infection after operation and, especially, after labor proceeds more rapidly and there is no time for the protective closure of the tube. The case was that of a colored woman who had been confined a month previously, and had been infected by her husband who was suffering from an acute gonorrhoea. There were evidences of acute peritonitis accompanied by vaginitis and urethritis. Abdominal section revealed a thickened, red and granular peritoneum; general soft adhesions of all the intestinal loops and parietes; no lymph, pus, or fluid. The Fallopian tubes were long, thick, and contained a little puriform fluid. The tubes and ovaries were removed close to the uterus and the abdomen flushed and drained. She made a good recovery. Microscopic examination of the tubes showed inflammatory infiltration and quantities of micrococci, not gonococci, but rather the staphylococci of suppuration.—*Medical News*, July 5, 1890.

**SYMPTOMS FOLLOWING CASTRATION.**—M. Weiss (Prague) has found these to be very similar to those observed in women after the climaxia, and this in both sexes. They appear usually in a few weeks: 1. Congestions; hot flashes as if hot water were poured over them, often beginning with an aura and quickly ascending from the abdomen to the head, followed by sweating and languor. 2. Perspiration over the whole body, but especially on the face. 3. Vertigo, may be slight and temporary or very severe. This may simulate petit mal with pale face, momentary unconsciousness, but no twitchings. 4. Palpitation of the heart with headache. 5. Loss of memory. 6. Gastro-intestinal troubles; nausea, vomiting, diarrhea or constipation. 7. Psychological disturbances, mostly of a melancholic nature with suicidal tendencies; loss of energy for work, of confidence in themselves, etc. In some seclusion becomes necessary, others become incurable.—*Wiener Medic. Presse*, No. 24, 1890.

**MULBERRY STONE IN A YOUNG CHILD.**—Dr. Hance presented a specimen of the above variety of vesical calculus to the New York Academy of Medicine, which he accidentally found while making a *post-mortem* examination of a child of twenty months who had succumbed to pulmonary tuberculosis and whooping-cough. There were no signs of pyelitis, nor had the child ever shown any symptoms of stone. It is a question, whether the concretion was congenital.—*New York Medical Journal*, July 5, 1890.

**URO-GENITAL TUBERCULOSIS.**—At the last meeting of the American Association of Genito-Urinary Surgeons two papers were read on this subject and gave rise to an interesting discussion. One paper, by Bryson (St. Louis), was a clinical study of eighty-four cases and twenty-four operations. The author's conclusions were that (1.) The bacillus reaches the parts involved by way of the blood. (2.) Several portions of the uro-genital system may be involved early in the history of the disease, perhaps simultaneously. (3.) The vicinity of the prostate is most liable to be involved early. (4.) The disease is, even in its earliest stages, a general one, with local manifestations. (5.) Operations, however radical, for the removal of localized lesions, do not insure a radical cure of the disease. (6.) Antitubercular treatment is the main reliance, surgical interference being reserved for the relief of pain, bleeding and suppuration. The other paper, by Bangs (New York), was the report of a case of obscure bladder trouble treated, after everything else had failed, including perineal section, by epicystotomy and prolonged drainage which gave relief. A number of papillary tumors on the thickened bladder walls and some hyperemic spots over the prostate were touched with the Paquelin cautery. A remarkable reflex manifestation was produced by touching a spot in the prostatic urethra; although the patient was deeply narcotized, pressure at this point caused a convulsive contraction of the bladder and abdominal muscles. No lesion, however, could be seen or felt, but this region had been found to be exquisitely tender previously. The principal points brought out by the discussion were that uro-genital tuberculosis usually belongs to the scrofulous or chronic variety. For the development of

the disease a constitutional soil and a local inflammatory focus are requisites. The bacillus is usually brought by the blood, but may descend with the stream of urine. It is a question whether it can travel against the current and probably is carried by the veins or the lymphatics. Primary tuberculosis of the testicle may occur but probably other lesions coexist or soon appear in the neighborhood, or at a distance. It is common in children and goes on to resolution with atrophy of the organ. Syphilis and tubercle may coexist and after the swelling caused by the former has disappeared under treatment, the characteristic nodules of the latter may be made out, or the fibroid testicle of syphilis may undergo subsequent tubercular change producing caseous lesions. Partial operations are preferable to ablation. The latter has been followed by rapid appearance of the disease in the other testicle which was apparently healthy, and this, although there appeared to be no involvement of the cord on the side operated. Acute lung tuberculosis has also rapidly supervened. Superficial lesions had best be scraped: deeper ones often become encapsuled. Accumulations should be evacuated to relieve tension, and operations in general limited to alleviation of pain and arrest of suppuration and systemic drain. The frequent appearance of lesions about the prostate may be due to this being the cross-road between the urinary and genital systems. Injections of nitrate of silver into the deep urethra only do harm, and the fact that lavage continuously aggravates the symptoms, is a point of diagnostic value. So are, also, the absence of spasm of the compressor-urethræ muscle, so frequently present in inflammations and neuroses about the prostate, and periods of great improvement, without apparent cause. Perineal drainage is useless and makes matters worse; this is best accomplished by the supra-pubic route and may be combined with cutting and burning with the Pacquelin all appreciable lesions. Iodoform oil and iodoform internally may be beneficial. Change of climate has been especially productive of good results, and to this should be added tonics, general hygiene and out-of-door life.—*Journal Cutaneous and Genito-Urinary Diseases*, July, 1890.

**GANGRENE OF THE FINGERS AFTER THE USE OF CARBOLIC ACID.**—Dr. Nazaris saw a man whose right middle finger had been amputated for sphacelus following a rat bite. Strong phenic acid had been applied as a dressing in mistake for the weaker solution. Numbness was first produced, and then mortification of the superficial tissue. He thinks that the condition was similar to that named by Lucas-Champonpière and Monod, *sphacèle phénique*.

Dr. Warfield, of Baltimore, has recently read a paper on carbolic acid gangrene (*Medical News*, April 12, 1890), and relates a personal observation. In October, 1889, an intemperate Irishman, fifty years of age, had applied to him for the relief of a gangrene of the right index finger. Four days previously he had crushed the member and applied a strong carbolic acid solution. This had caused considerable pain at first, but, the pain disappearing, the dressing was left on over night. The next day the finger was found blackened and inflamed. Since the literature of this subject dates only from 1888, at which time Kortüm published an article on Karbol-Nekrose, the writer makes a review of the cases reported, which, including his own, amount only to about twenty, and of these only six were reported in detail. It is a noteworthy fact that the gangrene was frequently produced by weak solutions, several being not stronger than eight and one only two per cent. A point of interest developed from the study of the reported cases is that complete envelopment of the circumference of the finger seems necessary to the production of gangrene. The gangrenous part corresponds to the skin area in relation with the drug.—*Journ. of Cut. and Gen.-Ur. Dis.*, July, 1890.

**A THIRD URETER OPENING INTO THE URETHRA.**—Dr. Velitz presented a fourteen-year-old girl to the medical society of Budapest, who had suffered since birth from dribbling of urine. On examination, the urethra was found to be very large in diameter, and in the left side of its upper third an opening was present into which a catheter was passed, going upward, backward, and towards the left; in a short time urine was voided through it in drops. Cystoscopic examination demonstrated that two normal openings from the ureters were present in the bladder, and that the third canal did not open into the bladder. Epicystotomy was performed and the ureter caused to open into the bladder above the sphincter vesicæ. Healing occurred without any febrile reaction, and since the operation—about a month—no dribbling of urine has occurred. No similar case is to be found in medical literature.—*Monatsh. für Prakt. Dermatol.*, Bd. 10, No. 12, 1890.



# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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CONDUCTED BY

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**CORROBORATION OF CHIONANTHUS SYMPTOMS.**—"While treating an obstinate case of recurring headache, and being disappointed in the failure of apparently indicated remedies that had relieved many times before, search was made for another drug. On account of *intense bruised feeling of the eyeballs and abdominal pains* chionanthus was prescribed. Two drops of the tincture were put in four ounces of water, and two teaspoonfuls given at 6 P.M. and again at 8 P.M. Before the latter hour the pains were much better, but the patient felt that she ought to have another dose, the abdominal pains having increased. The latter now became much worse, were not aggravated by pressure, and felt colicky. About 11 P.M. a stool occurred, with much wind and forcible gushing expulsion. *The odor was intensely fetid, and the patient complained that the stool burned the anus like fire.* The stool was watery, mixed with scybale, *both being nearly black in color.* A second stool occurred within half an hour, similar in every respect, and a third one, somewhat lighter in color, followed in about an hour. In the morning a fourth one came, yellowish-green in color, liquid, and not nearly so offensive. The headache was gone. As the patient never had such an experience before, and as the symptoms italicized are given in Lillienthal's *Therapeutics*, it is fair to take this as a proving of the drug.—Dr. J. T. O'Connor, *North American Journal of Homœopathy*, June.

**A CONFIRMATION OF A LACHESIS SYMPTOM.**—Dr. Clarke, in speaking about some of the complications occurring during the recent epidemic of influenza, speaks of the following case: "An old lady of seventy was suddenly attacked one evening with vomiting and headache. These got better, when she was taken with lumbago. Then this subsided and the headache returned—right-sided chiefly. One morning he found her paralyzed all down the left side. One peculiar symptom was confusion of mind as to time. She always imagined it was afternoon. Lachesis was the only medicine he could find corresponding to this, and under it the symptom rapidly disappeared. On giving another medicine for similar symptoms, and omitting the lachesis, the symptoms returned. Lachesis was given again, and again it disappeared, and the patient is rapidly recovering the power of her side."—*Homœopathic World*, June.

**BRITISH MEDICINAL PLANTS.**—Under the above caption Dr. Alfred Heath, in the *Homœopathic Physician*, July, continues his remarks concerning certain medicines, from which we briefly abstract, as follows:

*Ranunculus Sceleratus.*—The leaves of the plant are so very acrid that the beggars in Switzerland are said to produce very fetid and acrimonious ulcers by rubbing their legs with them. In the healthy the plant produces *laziness and want of disposition to perform any mental labor.* Many kinds of headache are produced; vomiting, sweetish taste in the mouth, profuse lachrymation, smarting in the eyes, earache of the right ear, smarting in the nose and excessive secretion of watery mucus, sneezing and toothache. It is useful for corns, with intolerable *burning*, stitches, pricking, sticking, boring pains along the whole sole of the right foot; itching and furious smarting of the soles, sudden stitches in the forepart of the

right big toe, as if a needle were thrust in deep, recurring at short intervals, sometimes passing into a burning.

*Ranunculus Flammula*.—A small quantity of the herb eaten produces vomiting, spasms of the stomach and delirium. Externally, it vesicates the skin. It produced gangrene of the arms down to the tendons and bones, when applied locally. In horses it causes excessive distension of the abdomen, and inflammation and gangrene of the abdominal organs.

*Ranunculus Ficaria*.—Deemed anti-scorbutic, and the root is esteemed a specific for piles. It has been used for external wounds, and bruises and spitting of blood. There is no proving of the plant.

*Ranunculus Repens*.—Produces smarting of the eyes, profuse lachrymation, and curious dreams. He fancies, while yet awake, that he is in a large city, and sees well-dressed people, masquerades, Turks, etc. The following were the effects of the plant upon a flock of sheep: Several fell down as if struck by lightning; the eyes rolled, and the breathing was hurried. Some reeled and died with their heads bent toward the left groin. The mucous membrane of the eyes was injected, the mouth dry, the abdomen slightly distended, and rumination ceased. Some of them raised themselves, reeled, fell down again, bleating pitifully; most were in profound coma. Sulphuric ether in milk gave much relief, but great weakness of the feet remained behind.

*Ranunculus Acria*.—Externally, it is a vesicatory. Applied to the temple it produces headache, intolerable heat and fainting. Applied to the joints, it produces soreness and obstinate ulcers as far as the knees: both feet look burned; red, hot blisters appear here and there; sometimes gangrene. Wounds of twenty years' standing began to improve after applying a decoction of the leaves to the legs.

*Ranunculus Bulbosus*.—Produces dread of labor; ill-humor and disposition to quarrel and scold; fear of being alone, afraid he will be haunted by ghosts. Smarting and soreness in the eyes and nose, with running.

**REMEDIES FOR DISTURBANCES OF SLEEP IN CHILDREN.**—Dr. Edwin A. Neatby, in the *Monthly Homœopathic Review*, July, gives an account of the causes of disorders of sleep in infants and their treatment, from which we abstract:

*Mercury*: Children suffering from inherited syphilis; restless and crying at night, probably from bone pains.

*Mezereum*: Nightly bone pains, causing wakefulness. Coryza, skin affections, and a wizened appearance. (Kali carbonicum is also sometimes useful in this condition).

*Silica*: Rickets, and the peculiar sleep disorders of that affection. As intercurrents, aconite, actea, belladonna, cina, coffea, conium, ignatia, or hyoscyamus, may be indicated.

*Pulsatilla*: Dyspepsia. Also nux vomica, rheum and sepia.

*Sambucus*: Bronchitis or spurious croup. Children may be found lying upon their backs with one or both hands thrown over the head. Also pulsatilla and antimonium tartaricum.

Much restless tossing, the bed-clothing kicked off, and the child found lying absolutely naked half a dozen times in the night (sometimes due, especially in rickets, to heat of the skin) suggests calcarea, ipecacuanha, sambucus, supplemented by chamomilla, hepar or phosphorus; and especially in rickets, silica and secale, supplemented by aconite or gelsemium.

Heavy sleep during the later stages of rickets; the child sleeps almost constantly, but probably with but half-closed eyes—Belladonna, opium, phosphorous acid and magnesia phosphorica are suggested, according to associated symptoms and conditions.

For sudden waking, with a look of terror on the face, or, in older children, on account of having dreamt of having seen something that frightened them, lachesis, belladonna, pulsatilla or chamomilla.

Grinding of teeth during sleep—cina, belladonna, kali carbonicum or hyoscyamus.

Children who lie awake several hours after being put to bed; patient, affectionate—pulsatilla.

Sleeping early and waking unduly early—sulphur, nux vomica, sepia and graphites.

Children who lie awake during the early part of the night from fear of being alone or fear of the darkness—hyoscyamus.

Moaning and groaning during sleep, followed by an unrefreshed waking—*pulsatilla*, *lycopodium*, *nux vomica*.

Movements of the mouth, like chewing, during sleep (often associated with flatulence and dyspepsia)—*byronia*.

Simple wide-awakeness, without fretfulness, or crying or tossing—*coffea*, *atropine* or *aconite*.

A *CICUTA* CASE.—Dr. E. W. Berridge cured, with a *cicuta virosa* 1m, a peculiar undiagnosed case, characterized principally by involuntary jerking of the feet, worse in the right foot, disturbing sleep, the jerking increasing to absolute plunging of the limb.—*Homœopathic World*, June.

PHOSPHORUS IN A CASE OF NEURALGIA.—"Miss D., 21 years, stationer, has had neuralgia two months. Pain in left temple and over left zymotic process. The pain is 'striking'; worse at night when she gets warm in bed. Very warm things and very cold things make the pain come on. Sometimes has feeling that 'top of head is lifting off.' Has palpitation and shortness of breath, also distension of stomach. Bowels regular. Patient is anemic-looking, and has bad teeth in the left lower jaw. I commenced treatment with *aconite* and *ferrum muriaticum*, but without good result. Then, I prescribed at different times *pulsatilla*, *belladonna*, *ignatia* and *sepia*, but with no relief. My patient would not face the dentist, and, as a last resource, I prescribed *phosphorus* 1, taking the carious teeth as the chief indication. The pain disappeared entirely within twenty-four hours and has not since returned. The palpitation, shortness of breath and distension of the stomach are also much better."—Dr. F. W. Thornton, *Monthly Homœopathic Review*, June.

IGNATIA IN CONVULSIONS.—Dr. J. Roberson Day, in the *Monthly Review* for July, tells of a bad case of whooping cough, complicated by severe bronchitis and repeated and violent convulsions, excited during every paroxysm of coughs, saved by *ignatia* 12th, after *ipêcacuanha*, *belladonna*, *drosera*, *aconite* and *cuprum aceticum* had failed. The child was in a dying state, exhausted, unable to take nourishment, and the jaws were spasmodically contracted.

NATRUM MURIATICUM IN COUGH.—"Although *natrum muriaticum* is not an especial cough remedy, yet it has a cough worthy of remembrance, that is, when he coughs he experiences pains in the abdominal ring extending into the testicles, as if the spermatic cord would be torn in pieces. With zinc the pain in coughing is in the testicles, so that he wants to hold them up with his hands."—Dr. A. McNeil, *Homœopathic Physician*, June.

PLANTAGO MAJOR IN WINTER COUGH.—Dr. Frederick Preston, in the *June Homœopathic Physician*, has the following: "Coming on regularly for twelve successive winters; constant cough during night and early morning. The victim had been obliged to pass his winter nights sitting on a stool; lying impossible. Many nostrums and some homœopathic medicines tried, among others *hyoscyamus*. The cough was without sputum, except when out doors. He had contracted the habit of going out into the cold air several times nightly during cold season to cough up a small portion of white, glairy mucus, which gave from one to three hours' relief. Three doses of *plantago major* 200 cured this cough within twenty-four hours. Since January 12, 1887, no return."

SEPIA IN CHRONIC BRONCHITIS.—Mrs. P. had had a severe cough for a year, and having consulted several physicians without benefit, concluded she had consumption, and that there was no help for her. I at first gave her *hepar* with some benefit, but a careful study of the case led me to think *sepia* was the remedy. The symptoms that led to the prescription were as follows: A loose cough, aggravated markedly morning and evening, and caused by a tickling, sometimes in the throat-pit and sometimes in the epigastrium; moist râles, and thick, greenish expectoration, and a few uterine symptoms now not definitely recalled. *Sepia* 30 cured in a little more than two weeks.—Dr. E. H. Linnell, *North American Journal of Homœopathy*, July.

IPECACUANHA IN PHLYCTENULAR KERATITIS.—Dr. Charles C. Boyle reports many corroborations of the value of *ipêcacuanha* in phlyctenular keratitis. The indications are the intense photophobia and pain, and the remedy has shown such remarkable results with the 30th that he has not felt the need of resorting to a lower potency.—*North American Journal of Homœopathy*, June.

**CAUSTICUM IN CATARACT.**—Dr. A. B. Norton reports, in the *North American Journal of Homœopathy* for June, the checking of the growth of a cataract with *causticum*, in varying potencies, from the 1st to the 30th.

**PULSATILLA IN CHLOROSIS.**—Agnes W., aged sixteen, menstruated for the first time six months ago, and again the following month. During the second month she took cold, and had not menstruated since. She then consulted Dr. E. H. Linnell. He found that she presented a perfect picture of chlorosis. She was much debilitated, had a loud bellows' murmur at the base of the heart, with much palpitation and dyspnoea. She had a livid, greenish complexion, had lost her appetite, and complained of sour eructations and constant headache, and a bad taste in the mouth, which was always worse in the morning. She always felt better in the open air. *Pulsatilla* 6x was prescribed, and when she was next seen, ten days later, the change in her appearance was surprising, and there was a very decided improvement in all her symptoms.—*North American Journal of Homœopathy*, July.

**GLONOINE IN ARTERIO-CAPILLARY FIBROSIS.**—Mr. G., nearly eighty years old, consulted Dr. E. H. Linnell on account of the following symptoms: Rapid and laborious action of the heart, with conscious pulsation of the peripheral arteries all over the body. Radial artery tense and firm. Pulse, 100. Shortness of breath. Tickling and dryness in the throat, causing a short, teasing cough, which was probably reflex from the excited heart's action. No valvular lesion or enlargement. Urine alternately scanty and profuse, but no evidence of nephritis. Glonoiné gave prompt relief, and he remained in good health, attending to his business regularly for a year. This spring, after an attack of the grip, he had a return of the same symptoms and glonoiné again gave prompt relief.—*North American Journal of Homœopathy*, July.

**ALUMINA IN DIARRHŒA.**—Dr. Rogers tells about a case that came into his hands after having been treated by other physicians—a child who had been long sick with diarrhœa. He prescribed what seemed to be the indicated remedies with no effect. During one of his visits the mother said to him: "Doctor, what makes my child want to eat dirt? He will dig it out of the cracks of the floor, and eat it whenever he can get it." Upon this symptom the doctor prescribed *alumina*. The next day he found the patient better, and he was well in a few days.—*Homœopathic Physician*, July.

**NUPHAR LUTEUM IN CHRONIC DIARRHŒA.**—Dr. E. H. Linnell cured a dark, watery diarrhœa, preceded by sudden urging, attended with slight pain, worse in the early morning, with *nuphar luteum*.—*North American Journal of Homœopathy*, July.

**REMEDIES FOR LEUCORRHŒA.**—Dr. Charles Hoyt, in the June *North American Journal of Homœopathy*, concludes an article on "Leucorrhœa," with the following indications for remedies:

*Aesculus hippocastanum*.—Leucorrhœa with lameness across the back so that walking is difficult, constipation, hæmorrhoidal troubles, feeling as though there were sticks in the rectum.

*Alumina*.—Profuse yellow, acrid, corroding discharges, burning the genitals; very profuse and acrid discharge, worse in daytime; worse before and after the menses, running down to heels in large quantities; constipation, with inactivity of the rectum; leucorrhœa relieved by bathing in cold water.

*Ambra grisea*.—Leucorrhœa only at night, bluish-white mucus, stitches in the vagina before the discharge.

*Borax*.—Leucorrhœa midway between the menstrual terms; sensation as though warm water were flowing down; nervousness; cannot bear a downward motion or horseback riding.

*Belladonna*.—Leucorrhœa with colicky pains, appearing suddenly and as suddenly disappearing; bearing-down pains, as if the womb would push out; tenderness of the abdomen.

*Bovista*.—Leucorrhœa after the menses, flowing only at night; thick, slimy, tenacious, acrid and corrosive.

*Culcarea carbonica*.—Profuse milk-like discharge, with soreness and swelling of the vulva, menses too early and too profuse; scrofulous subjects, very sensitive to cold; damp feet, as though she had on damp stockings; leucorrhœa of children.

*Cantharis*.—Discharge of bloody mucus after urinating; frequent urging to urinate, with cutting and burning; increased sexual desire; gonorrhœa.

*Curbo vegetabilis*.—Great foulness of all secretions; discharges very acrid, excoriating the parts; itching of the genitals; flatulency; soreness and rawness of the external genitals.

*China*.—Leucorrhœa before the menses; great debility; bloody leucorrhœa, with occasional discharges of black, fetid, purulent matter.

*Occlusus*.—Scanty, irregular menses, or leucorrhœa instead of the menses; great sense of prostration and weakness.

*Collinsonia*.—Leucorrhœa, with pruritus and obstinate constipation.

*Conium*.—Indurations, especially of a scrofulous nature, or from injuries; prolapsus uteri, complicated with induration, ulceration and profuse leucorrhœa.

*Kreosote*.—Leucorrhœa, smelling like green corn; mild and painless as well as putrid and corroding leucorrhœa; often indicated for old ladies and young girls.

*Graphites*.—Profuse leucorrhœa day and night, with great weakness of the small of the back; skin irritable and ulcerating easily; constipation; stools large and knotty.

*Helonias*.—Leucorrhœa with anæmia and general torpid condition of the system; prolapsus uteri; adapted to women worn out with hard work, whose strained muscles burn and ache; relief from being actively employed; consciousness of a womb.

*Hydrastis*.—Yellow leucorrhœa of a tenacious character, hanging from the os in long viscid strings.

*Kali bichromicum*.—Yellow, ropy, tough leucorrhœa; can be drawn out in strings.

*Lachesis*.—Leucorrhœa from three to eight days before the menses; copious, smarting, slimy, stiffening the linen and staining it green; cannot bear any pressure, not even the clothing upon the uterine region.

*Lycopodium*.—Leucorrhœa accompanied by a cutting pain across the hypogastrium, from right to left; red sandy sediment in the urine, resembling brick dust.

*Mercurius solubilis*.—Leucorrhœa, worse at night; itching, burning and smarting; scorbutic gums and enlarged tonsils; leucorrhœa purulent in character.

*Natrum muriaticum*.—Acrid, green leucorrhœa, especially when walking; pimples on the mons veneris; chlorotic, cachectic patients, with sallow skin; palpitation; oppression of the chest; delayed and scanty menses, with headache.

*Nitric Acid*.—Leucorrhœa, consisting of flesh-colored mucus; syphilitic ulcerations; brown urine, strong, fetid odor; pruritus, with stitches in the vagina.

*Nux Moschata*.—Leucorrhœa of women who always awaken with a very dry tongue.

*Nux Vomica*.—Fœtid leucorrhœa, tinting the linen yellow; backache; frequent ineffectual efforts to stool; patients that have been drugged.

*Phosphorus*.—Smarting leucorrhœa, drawing blisters; suitable to tall and slender persons with phthisical habits.

*Phosphoric Acid*.—Leucorrhœa after the menses; great sense of weakness, with a remarkable state of indifference; passes large quantities of colorless urine.

*Pulsatilla*.—Thin, acrid leucorrhœa, or thick white mucus, most profuse after menses; menses too late and scanty, with abdominal cramps; flat, nasty taste; symptoms worse in the evening; relieved in the open air; mild, tearful, yielding disposition.

*Psorinum*.—All excretions, leucorrhœa, menstrual flow, perspiration, eructations, have a carrion-like odor; especially adapted to the psoric diathesis; in chronic cases, when well-selected remedies fail to improve; debility, with lack of reaction after severe acute diseases.

*Sabina*.—Yellowish, corrosive leucorrhœa, making the thighs sore, causing intense itching; during pregnancy and after delivery; painful, active congestion of the uterus.

*Secale Cornutum*.—Leucorrhœa of thin, scrawny women, with prolapsus uteri; subject to passive hæmorrhages; tendency to gangrene.

*Sepia*.—Suitable to feeble and debilitated women of a dark complexion; yellow saddle across the nose; milky leucorrhœa only in the daytime; sudor hystericus; peculiar fœtid perspiration, particularly from the genital organs, axillæ and soles of the feet; fetid, putrid urine, depositing a yellow, clay-colored sediment, adhering to the bottom and sides of the vessel; sensation as if everything would press out of the vagina, having to cross their legs to prevent it; painful sensation of emptiness and goneness in the pit of the stomach.

*Stannum*.—Leucorrhœa, with marked loss of strength, the weakness seeming to proceed from the centre of the chest; menses too early and too profuse.

**Sulphur.**—Leucorrhœa, smarting like salt; scanty, acrid leucorrhœa, causing soreness of the vulva; constipation; diarrhœa, driving the patient out of the bed in the morning; burning of the soles of the feet; heat on the top of the head; stooped shoulders, cannot walk erect.

**Thuja.**—Cancer and scirrhus of the uterus; wart-shaped excrescences at the orifice of the uterus; fig-warts all over the genitals.

**Zincum.**—Leucorrhœa consequent upon masturbation, and attended with nervous exhaustion; restlessness of the feet, she cannot keep them still; chronic, excessively violent and obstinate headache.

**XANTHOXYLUM IN UTERINE PAIN.**—Dr. R. K. Gosh concludes the report of two cures of cases of after-pains, as follows: I have been led to the conclusion that xanthoxylum is useful in dysmenorrhœa, with *menorrhagia*, with pain of *neuralgic* and *remittent* or continuous character, especially the former. Where the pains are intermittent xanthoxylum is not useful.—*North American Journal of Homœopathy*, June.

**XANTHOXYLUM IN "AFTER-PAINS."**—Dr. R. K. Gosh, in the June *North American Journal of Homœopathy*, reports two cases of severe after-pains almost magically relieved by *xanthoxylum* in drop doses of the tincture.

**ARSENICUM IN NEPHRITIS.**—Dr. Oscar Hansen treated a musician, aged thirty-six, who complained of a little faintness, thirst, rotten taste; good appetite and sleep; no œdema; oppressing pains in the loins and down the thighs; made water three times in the night. Quantity of urine in twenty-four hours, 2½ quarts; urine pale, frothy, clear, slightly acid; specific gravity, 1016, and contained 1½ per cent. albumin and a few cylindrical casts. He had burning pains from time to time in the urethra during and when not making water, but never any incontinence. *Arsenicum-album* 3c was prescribed, three drops three times daily. The time of treatment was from the 25th of November, 1887, to December 31, same year, when he was discharged cured, the urine being normal and all symptoms having disappeared.—*Homœopathic World*, July.

**NATRUM MURIATICUM AND RHUS TOXICODENDRON IN HYDROA.**—"On the first appearance the rhus blister is clear and translucent, with a tendency to amber color. The natrum muriaticum blister is not as clear, but of a whitish or pearl color, nearly or quite opaque, and during its undisturbed progress does not change its color as soon as that of the rhus. The natrum muriaticum blister is more likely to be discrete, while the rhus tends more to confluence or groups."—Dr. G. M. Pease, *Homœopathic Physician*, June.

**RHUS TOXICODENDRON IN ERYSIPELAS.**—Dr. E. E. Keeler cured a severe case of erysipelas very rapidly with rhus toxicodendron, locally and internally.—*American Homœopathist*, June.

**APIS IN ERYSIPELAS.**—Dr. E. Elmer Keeler, in the June number of the *American Homœopathist*, reports an exceedingly rapid cure of a case of erysipelas with apis mellifica.

**GRAPHITES IN ERYSIPELAS.**—Dr. H. C. Houston gave *graphites* 12 to a patient suffering from a desperately severe case of erysipelas ambulans, after the usual remedies had failed, with great success. The indications were that the sufferer was a "graphites patient."—*Clinical Reporter*, June.

**ANTIMONIUM CRUDUM IN ECZEMA.**—Miss T., about thirty years of age called upon Dr. E. H. Linnell, presenting the following conditions: She had an eczematous inflammation of both auditory canals. The skin was swollen and infiltrated to such a degree that the passage was almost closed. The surface was somewhat scaly, and there were several fissures exuding a slight amount of thick serum. She also had a scaly ciliary blepharitis, and the conjunctiva of the left eye was somewhat swollen. The corners of her mouth were cracked and sore, and also the edges of the nostrils. She had a cachectic, anemic appearance; she was somewhat debilitated, and frequently vomited her food soon after eating, but had no special sensations of distress in the stomach, or nausea. The doctor gave her antimonium crudum 6x; she came back in ten days no better; she then received the same remedy in the 2c. She reappeared in a year with the same train of symptoms, stating that the last medicine had cured her, but the symptoms had recurred. The 6th was again tried and failed as before; but the 2c was followed by a prompt cure.—*North American Journal of Homœopathy*, July.

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OBSTETRIC MEDICATION.

BY GEO. B. PECK, M.D., PROVIDENCE, R. I.

(Read before the American Institute of Homœopathy.)

AT the last session of the Institute the chairman of this bureau, distinguished alike as an instructor and as an author, stated that "many of the symptoms given us as a foundation for prescription are illusive, delusive and ensnaring." At the same time he promised to add to the indications given in his works as soon as he shall find more that are reliable. Thus originated this paper in which have been scrutinized carefully the therapeutics of our art exhibiting that symptomatology only which has been proved to be *probably* or *positively* trustworthy.

The foundation of homœopathic medication is drug action on the healthy. Pregnancy and parturition alike are but physiological conditions. The madman alone, however, would dream of proving drugs in their presence. Fortunately, all phenomena requiring the interposition of medicaments (save an insignificant few which may be designated for convenience as accidental) are the manifestation of pre-existent, independent abnormalities, whose exhibition is but slightly modified (comparatively) by the supervention of unusual conditions. It follows, then, that the means for their eradication are to be sought precisely in the lines pursued in the treatment of uncomplicated disorders.

Henry N. Guernsey's text-book is unquestionably the basis of most of our obstetric medication. This is not singular, for to rare

acquaintance with *Materia Medica* he added unusual experience as an accoucheur. A limited number of indications have been added thereto by Clarence M. Conant in his *Obstetric Mentor*. All found in either volume have been tested by the only existing touchstone, Allen's *Encyclopædia*. The principles under which the examination was conducted are few and simple. If a symptom is reported but by a solitary prover it *may* be an effect of the drug; if two independent investigators note it, there is strong *probability* the medicament had somewhat to do with the circumstance; if three isolated observers testify to the same experience, the relation between *cause* and *effect* is too *evident* to be gainsaid by any prudent individual. Italicized symptoms are, therefore, to be considered solid rock, while the remainder are sufficiently hard pan to enable one safely to build thereon. A limited number of parenthetical indications have been similarly added at convenience, partly to elucidate the regular text and partly to denote the manner in which our therapeutics may be securely amplified.

The omission of many familiar and well-tried indications will be noted. This is because of their observance but by single provers. The symptomatology of the several drugs as reported also presents other singular features. The lessons are so clear that none but the blind can fail to read them.

The severe and protracted clerical labor necessitated by the presentation of this report was performed by my student, Miss Frances A. Kenyon, late of the classical department of Providence High School, under my immediate supervision. Without her valuable assistance the preparation of the paper would have been impossible. In the arrangement of topics, Sheldon Leavitt was followed.

#### ABORTION.

ACONITE.—*Anxiety; apprehensiveness, especially of approaching death; vertigo on motion.*

APIS.—*Ovarian irritation; profuse and frequent micturition (occasionally scanty); light colored diarrhœa.*

ARNICA.—*Sensation as if bruised.*

BELLADONNA.—*Pressure and bearing-down in uterine regions; eyes red; flushed face; hot, throbbing head; jars unpleasant.*

BRYONIA.—*Pain in back, worse on motion; head aches as if it would split; great thirst; pain all over; dryness in mouth; nausea; constipation; dry, hard stool.*

CALCAREA CARB.—*Menses appear too early; vertigo.*



CANTHARIS.—*Constant urging to urinate, sometimes ineffectual.*

FERRUM.—*Flushed face.*

GELSEMIUM.—*Loss of will-power over the muscles.*

IPECACUANHA.—*Nausea.*

NUX MOS.—*Mouth and throat very dry.*

NUX VOMICA.—*Urgings to urinate.*

SABINA.—*Drawing pains in small of back.*

SECALE COR.—*Pulse slow; great anxiety.*

SEPIA.—*Constipation; urging and straining; inclined to faint, more so on motion.*

SILICEA.—*Constipation of difficult stools.*

SULPHUR.—*Faintness; leucorrhœa.*

#### RETAINED PLACENTA.

BELLADONNA.—*Redness of face; heat and dryness of surface.*

CANTHARIS.—*Nausea with vomiting; anxiety; feverishness; pain in abdomen and back.*

PULSATILLA.—*Tearful.*

SECALE C.—*Urine retained.*

#### NAUSEA.

ACONITE.—*Nausea and vomiting, with thirst; fear of death; bitter taste in mouth; burning and pains in stomach (especially after eating); sense of weight; tingling of tongue.*

AGARICUS.—*Burning, itching, and redness of ears, toes and fingers; itching of nose; burning and redness of face; much hunger, but no appetite.*

ALUMINA.—*Heartburn; eructations; the peculiar alumina constipation may characterize the whole case.*

ANGUSTURA.—*Stitches in tongue.*

ANTIMONIUM C.—*Nausea and violent vomiting; thirst at night.*

APIS MEL.—*Absence of thirst, or great thirst.*

ARGENTUM N.—*Vertigo; belching.*

ARNICA.—*Heat in head.*

ARSENICUM.—*Very great debility and exhaustion; uneasy and restless; bitterness in mouth; very pale look; diarrhœa; vomiting of fluids; vomiting of greenish matter.*

BELLADONNA.—*Pale or flushed face; nausea, vomiting; coating on the tongue.*

BRYONIA.—*Nausea; vomiting of foods; dry mouth; hard stool.*

CANTHARIS.—*Frequent micturition, with cutting and burning*

pains, but few drops at a time, and sometimes blood; vomiting, with violent retching and severe colic.

CARBO VEG.—*Frequent eructations; itching of anus.*

CAUSTICUM.—*Painful hæmorrhoids; constipation; risings of air.*

CHAMOMILLA.—*Nausea; irritable temper.*

GRAPHITES.—*Much headache.*

LYCOPODIUM.—*Rumbling in abdomen; bitter or sour taste.*

MAGNESIA CARB.—*Sour taste; eructation.*

MAGNESIA MUR.—*Eructation; nausea; bitter taste.*

MERCURIUS V.—*Much salivation; ulcerated gums.*

MOSCHUS.—*Violent eructations.*

NATRUM MUR.—*Nausea in the morning; aversion to bread; water-brash; heart-burn; much hunger, but no appetite; bitter or sour taste; palpitation of the heart.*

NITRIC ACID.—*Much nausea.*

NUX MOSCH.—*Mouth, tongue and throat very dry; disposition to faint; great sleepiness.*

NUX VOMICA.—*Nausea and vomiting; not much appetite; eructation; restless sleep; constipation.*

OPIUM.—*Constipation.* (Evacuation of small hard nodules.)

SABADILLA.—*Much nausea; burning in the stomach extending up as far as the throat; sweetish taste.*

SEPIA.—*Aversion to meat; nausea in the morning; want of appetite; eructations.*

SILICIA.—*Nausea; constipation.* (Dry, hard, light-colored stools.)

STAPHISAGRIA.—*Extreme hunger even when stomach is full of food; constant accumulation of water in mouth.*

STRAMONIUM.—*Great thirst; nausea.*

SULPHUR.—*Flashes of heat; heat on top of the head; cold feet; short sleep at night, wakes very frequently; eructations; vomiting; bitter or sour taste.*

SULPHURIC ACID.—*Coldness in stomach; eructations; loss of appetite; vomiting; tremulousness.*

VALERIAN.—*Nausea.*

VERATRUM.—*Nausea; feels weak and faint.*

ZINC.—*Great greediness when eating; much nausea and vomiting.*

#### PRURITUS.

APIS.—*Eruptions; stinging, like bee stings.*

CANTHARIS.—*Burning; frequent micturitions, with burning and cutting.*

CARBO VEG.—*Itching of the anus.*

CONIUM M.—*Milky leucorrhœa.*

LYCOPODIUM.—*Constipation.*

SEPIA.—*Leucorrhœa (yellowish, creamy).*

SILICIA.—*Constipation (dry, hard, light-colored stool).*

#### CEPHALAGIA.

ACONITE.—*Sensation as if the brain would press out at the forehead.*

ACTEA.—*Pain over either eye or in the eyeball.*

BELLADONNA.—*Flushed face and injected eyeballs ; cannot bear bright light ; stupid condition ; right-sided headache ; toothache after eating.*

BRYONIA.—*Dryness of mouth and lips ; constipation.*

CALC. CARB.—*Headache (pressive, in forehead).*

GELSEMIUM.—*Heaviness of the head ; vertigo ; powerlessness of the muscles ; dimness of vision.*

GLONOIN.—*Throbbing in the temporal arteries ; sensation as of expansion of the brain, the head feeling as though it would burst.*

MAGNESIA C.—*Constipation.*

NUX VOMICA.—*Constipation of the bowels ; nausea.*

PULSATILLA.—*Given to weeping.*

SEPIA.—*Headache ; aversion to food ; nausea ; vertigo ; stitching toothache.*

SPIGELIA.—*Pressive pain in the eyeball and orbit ; left-sided headache.*

SULPHUR.—*Heat in head and flushes of face ; cold feet ; faintness.*

VERATRUM A.—*Nausea and vomiting ; diarrhœa or constipation.*

#### CHOREA.

BELLADONNA.—*Difficult articulation and deglutition ; tongue as if paralyzed ; red eyes ; stupid ; debility.*

HYOSCYAMUS.—*Jerking and twitching of all the muscles ; twitching of the muscles of the face.*

NUX VOMICA.—*Constipation.*

STRAMONIUM.—*Hallucinations ; full of strange inconsistencies ; laughter ; jactitation of the muscles.*

#### SYNCOPE.

ACONITE.—*Palpitation of the heart.*

ARSENICUM.—*Debility or prostration.*

BRYONIA.—Great thirst and drinks much cold water.

CARBO VEG.—*Eruclations.*

CHAMOMILLA.—*Irritability ; dimness of vision ; nausea.*

CHINA.—Cold perspiration ; *ringing in the ears.*

CAMPHOR.—*Very weak pulse ; coldness of the whole body.*

COCCULUS INDICUS.—*Paralyzed feeling in all the limbs, with trembling.*

DIGITALIS.—*Pulse slow and irregular ; cold sweat.*

IGNATIA.—*Much trembling.*

NUX VOMICA.—*Vomiting ; trembling.*

SEPIA.—*Feet and hands cold as ice ; flushes of heat.*

STRAMONIUM.—*Fainting ; pale face.*

VERATRUM A.—Cold sweat upon the forehead.

#### TOOTHACHE.

ALUMINA.—Drawing toothache.

ARSENICUM.—*Toothache, occurring at night.*

BELLADONNA.—*Toothache at night and after eating.*

CALCAREA CARB.—Toothache.

CHAMOMILLA.—*Toothache ; swelling of the gums.*

GELSEMIUM.—*Weak and trembling ; toothache.*

HYOSCYAMUS.—Spasms in the throat ; toothache.

MAGNESIA C.—Toothache (tearing, drawing, chiefly in back teeth ; worse at night).

MERCURIUS SOL.—*Toothache ; the teeth feel as if loose.*

MEZEREUM.—*Toothache ; teeth seem blunted, elongated, decay rapidly ; pressive, cutting or drawing pain in back teeth.*

NUX M.—Toothache ; *jerking in back teeth, from contact with cold, particularly if on left side.*

NUX V.—Constipation.

PHOSPHORUS.—Jerking toothache.

PULSATILLA.—Inclines to tears.

RHUS TOX.—Toothache.

#### CONSTIPATION.

ACONITE.—Much thirst ; fear of death.

ALUMINA.—Scanty, hard stool.

AGARICUS M.—*Loud rumbling in the bowels.*

ARNICA.—*Flatulency ; colic ; foul smelling flatus.*

BELLADONNA.—*Flatulency ; obstruction of the bowels ; much ten-*

*dency of blood to the head ; red eyes ; intolerance of light ; flushed face ; heat in the head.*

**BRYONIA.**—*Much thirst ; rumbling in abdomen ; irritable ; mouth and lips dry ; hard stool.*

**CARBO VEG.**—*Flatulency, with colic and rumbling in bowels.*

**CAUSTICUM.**—*Constipation ; rumbling in the bowels.*

**CHINA.**—*Flatulence, with colic ; rumblings.*

**CONIUM.**—*Much vertigo.*

**GRAPHITES.**—*Hard stool ; itching blotches about the body ; colic.*

**IGNATIA.**—*Empty feeling at the pit of the stomach ; rumbling.*

**KALI C.**—*Unsuccessful desire for stool.*

**LYCOPodium.**—*Rumbling and gurgling ; incarcerated flatulence.*

**MERCURIUS.**—*Salivation ; gums sore.*

**NATR. M.**—*Hard stool ; rumbling of flatus and incarceration ; headache on awaking in the morning ; aversion to bread ; sore places in mouth.*

**NITRIC ACID.**—*Hard stool ; bloody stool ; much flatus.*

**NUX MOSCH.**—*Dryness in mouth and tongue ; stool slow and difficult.*

**NUX VOM.**—*Flatulence.*

**OPIUM.**—*Sleeplessness.*

**PHOS.**—*Blood with the stool.*

**PHOSPH. ACID.**—*Flatulency ; stool hard.*

**PLUMBUM.**—*Constipation, with colic ; stools composed of little balls like sheep's dung ; flatulency ; colic.*

**PULSATILLA.**—*Bloody stool.*

**SEPIA.**—*Stool difficult ; flatulency, with loud rumbling in the abdomen.*

**STAPHISAGRIA.**—*Offensive flatus.*

**SULPHUR.**—*Piles ; coldness of the feet ; rumbling in abdomen, with offensive flatus ; hard stool with blood.*

**VERATRUM A.**—*Flatulency ; colic.*

**ZINC.**—*Dry stool.*

#### DIARRHŒA.

**ALOE.**—*Feeling as if the stool could not be retained, but must drop involuntarily ; rumbling in the bowels.*

**ALUMINA.**—*Diarrhœa ; tenesmus ; stools bloody and scanty.*

**ANGUSTURA.**—*Diarrhœa.*

**ARNICA.**—*Bruised feeling all through the body.*

ARSENICUM.—*Diarrhœa ; bloody or involuntary stools ; very weak, least motion causing great fatigue.*

AURUM.—*Nightly diarrhœa.*

BELLADONNA.—*Flushed face ; red eyes.*

BRYONIA.—*Burning diarrhœa ; thirst.*

CANTHARIS.—*Constant desire to urinate, with cutting burning pain.*

CAPSICUM.—*Burning in the anus.*

CARBO VEG.—*Much flatulency.*

CHAM.—*Nightly diarrhœa with colic ; very irritable temper.*

CHELIDONIUM.—*Diarrhœa (pasty or watery, bright yellow ; lighter colored than usual ; light-red or brown).*

CHINA.—*Diarrhœa ; undigested food ; sensation of distension in abdomen.*

COLOCYNTH.—*Diarrhœa ; pappy stools, with or without burning at the anus ; preceded by colic, but not necessarily ; with or without tenesmus ; flatulence ; yellow, brown, bloody, greenish.*

CONIUM.—*Diarrhœa.*

CUPRUM MET.—*Diarrhœa (green).*

DIGITALIS.—*Violent diarrhœa ; ash-colored ; nausea ; vomiting of food.*

DULCAMARA.—*Stools yellowish ; worse after every cold change of the weather.*

FERRUM.—*Frequent diarrhœic stool.*

GELSEMIUM.—*Depressed state of mind.*

GRAPHITES.—*Diarrhœa ; much flatulency.*

HEPAR.—*Diarrhœa (urgent desire, preceded by griping, worse at night, with tenesmus).*

HYOSCYAMUS.—*Diarrhœa (frequent stool ; slimy).*

IGNATIA.—*Empty, weak feeling at the pit of the stomach.*

IPECAC.—*Diarrhœa (greenish).*

IRIS VERSICOLOR.—*Severe burning in the anus during stool ; foetid flatulence ; nausea and vomiting ; rumbling in the bowels.*

KALI C.—*Diarrhœa (profuse, with much weariness or severe pain low down in abdomen ; insufficient discharge).*

LACHESIS.—*Diarrhœa.*

LAUROCERASUS.—*Diarrhœa.*

LEDUM.—*Diarrhœa.*

LEPTANDRA.—*Fluid, foetid stools, with difficulty of retaining the stool.*

LYCOPodium.—*Diarrhœa ; much flatulence.*

MERCURIUS.—*Diarrhœa ; salivation ; ulcerated gums ; loose teeth.*

MEZEREUM.—*Diarrhœa.*

MURIATIC ACID.—*Diarrhœa; very weak.*

NATR. MUR.—*Diarrhœa, like water; aversion for bread; vivid dreams; headache on waking.*

NUX MOSCH.—*Diarrhœa* (stools soft but difficult to pass).

NUX VOM.—*Want of appetite.*

OPIUM.—*Watery diarrhœa, sometimes frothy; drowsiness, but unrefreshing sleep.*

PHOS.—*Watery diarrhœa; general debility.*

PULSATILLA.—*Rumbling of flatulence; chilliness; tearful disposition.*

RHUS.—*Diarrhœa; bloody stools; restlessness.*

SECALE C.—*Diarrhœa* (fetid, dark-colored).

SEPIA.—*Exhausting diarrhœa.*

STRAMONIUM.—*Diarrhœa; great thirst; great loquacity.*

SULPHURIC ACID.—*Diarrhœa* (black, offensive).

TABACUM.—*Diarrhœa; sudden faintings.*

VERATRUM ALB.—*Diarrhœa; cold sweat on the forehead; genera cold perspiration.*

#### FALSE PAINS.

ACONITUM.—*Fears that she will die.*

ARNICA.—*Flushing of face.*

AURUM.—*Palpitation of the heart.*

BELLADONNA.—*Injected eyeballs and red face; throbbing headache.*

CHAMOMILLA.—*Fretful; peevish; tearing pains down the legs.*

CAMPHOR.—*Skin cold and dry; restless.*

COCCULUS.—*Paralyzed feeling of lower limbs; headache.*

COFFEA.—*Mental excitement.*

CONIUM.—*Vertigo.*

CUPRUM.—*Restlessness.*

HYOSCYAMUS.—*Delirium; startings and jerks in various parts of the body.*

IPECACUANHA.—*Persistent nausea.*

KALI C.—*Eructations.*

NATRUM C.—*Perspiration.*

NATRUM M.—*Sad.*

NUX M.—*Sleepiness.*

OPIUM.—*Red face; stertorous breathing; twitching of the muscles.*

PHOSPHORUS.—*Cutting pains in abdomen.*

PULSATILLA.—*Tearful disposition.*

RHUS TOX.—*Restless.*

RUTA.—*Weak ; small pulse.*

SEPIA.—*Empty feeling in stomach.*

SULPHUR.—*Cold feet ; fainting feeling.*

VERATRUM.—*Cold sweat, particularly on the forehead ; faintness.*

#### HÆMORRHOIDS.

ACONITE.—*Restlessness.*

ÆSCULUS HIPPI.—*Purple-colored piles, which do not bleed ; pressure in the rectum.*

ALOES.—*Mucus discharged per anum.*

APIS.—*Restlessness at night.*

ARSENICUM.—*Pain in the back ; great weakness and restlessness.*

BELLADONNA.—*Dysuria ; congestion of blood in head ; throbbing headache.*

CAPSICUM.—*Burning in anus ; drawing pain in back.*

CARBO VEG.—*Itching in the anus ; flatulence.*

CAUSTICUM.—*Painful hæmorrhoids.*

CHAMOMILLA.—*Irritable.*

CHINA.—*Hæmorrhoids.*

COLOCYNTH.—*Persons subject to violent attacks of cramp colic.*

HAMAMELIS.—*Restlessness at night ; frontal headache.*

LYCOPODIUM.—*Much rumbling in abdomen ; red sediment in urine ; varices protrude.*

NUX VOMICA.—*No appetite ; headache.*

PULSATILLA.—*Tearful disposition.*

RHUS TOX.—*Restlessness.*

SEPIA.—*Sensitive skin.*

SULPHUR.—*Itching and soreness of the anus ; very cold feet ; awakens frequently at night ; fainting feeling ; despondency.*

THUJA OCC.—*Vertigo ; backache.*

#### RIGIDITY OF THE OS UTERI.

ACONITE.—*Restlessness ; fears she will die ; anxious.*

BELLADONNA.—*Fainting.*

CHAMOMILLA.—*Irritability.*

LOBELIA INFLATA.—*Dyspnoea.*

#### HOURLY CONTRACTIONS.

BELLADONNA.—*Injected eyeballs ; flushed face ; cannot bear light or noise ; pulse full ; hot skin.*



CHAMOMILLA.—*Irritability ; thirst.*

COCCULUS INDICUS.—*Frequent vomiting ; paralyzed feeling of lower limbs.*

CONIUM.—*Vertigo.*

HYOSCYAMUS.—*Delirium ; jerking and twitching of the muscles.*

KALI C.—*Stitching pain in abdomen ; thirst.*

NUX VOM.—*Mental depression.*

PULSATILLA.—*Tearful disposition.*

RHUS TOX.—*Restless.*

SEPIA.—*Flushes of heat ; cold feet.*

SULPHUR.—*Weak and fainty spells ; cold feet.*

#### ACCIDENTAL HÆMORRHAGE.

ACONITE.—*Fear of death.*

ANTIMONIUM C.—*Nausea and vomiting.*

APIS.—*Yawning.*

ARGENTUM NIT.—*Confusion.*

BELLADONNA.—*Flushed face ; pulse full ; hot head.*

BRYONIA.—*Dry mouth ; nausea.*

CALCAREA CARB.—*Vertigo.*

CANTHARIS.—*Irritation in neck of bladder ; urinating often ; cutting and burning in passing only a few drops.*

CARBO VEG.—*Itching in anus.*

CHAMOMILLA.—*Tearing pain in limbs ; irritability.*

CHINA.—*Colic ; heaviness of head ; ringing in the ears ; fainting.*

FERRUM.—*Vertigo ; headache ; constipation.*

HYOSCYAMUS.—*Delirium ; startings and jerks in various parts of the body.*

IODIUM.—*Pain in small of back.*

IPECACUANHA.—*Nausea and vomiting ; headache ; pale.*

NUX MOSCH.—*Dryness of mouth and tongue ; sleepiness.*

PHOSPHORUS.—*Eruclations after eating ; constipation.*

PULSATILLA.—*Tearful temperament.*

SECALE C.—*Debility ; cold.*

SEPIA.—*Icy cold feet ; flushes of heat ; constipation ; sensation of "goneness" at the pit of stomach.*

SILICEA.—*Constipation (dry, hard, light-colored stool).*

STRAMONIUM.—*Full of strange ideas ; loquacious.*

SULPHUR.—*Weak and fainting spells ; cold feet.*

#### LOCHIA.

ACONITE.—*Feverishness, with thirst ; cutting pains in abdomen,*

*which is very tender on pressure ; fears she will die ; fearfulness ; uneasiness.*

BAPTISIA.—Prostration.

BELLADONNA.—*Flushed face ; injected eyeballs ; delirium ; great tenderness of the abdomen ; drowsiness.*

BRYONIA.—*Dryness in mouth ; thirst.*

CHAMOMILLA.—*Irritable ; thirst ; diarrhœa.*

COLOCYNTH.—*Violent colic ; tympanitic abdomen ; diarrhœa.*

HYOSCYAMUS.—*Delirium ; jerking of the muscles.*

RHUS TOX.—*Restlessness at night.*

SECALE C.—*Dark discharge.*

STRAMONIUM.—*Full of strange ideas.*

SULPHUR.—*Perspiration ; cold feet.*

#### LACTATION.

ACONITE.—*Much thirst ; dry skin ; anxiety ; restlessness.*

BELLADONNA.—*Flushed face ; injected eyeballs ; throbbing headache ; full pulse ; cannot bear light or noise ; sleeplessness.*

BRYONIA.—*Dry mouth ; nausea ; constipation (stool large, hard, dry, expelled with difficulty).*

CAUSTICUM.—*Anxiety.*

CHAMOMILLA.—*Fretful ; sleepless.*

CHINA.—*Fulness in abdomen.*

MERCURIUS.—*Ptyalism.*

PULSATILLA.—*Feverish ; tearful disposition.*

SEPIA.—*Sensitive skin ; flushes of heat ; cold hands and feet.*

SILICEA.—*Constipation (dry, hard, light-colored stool).*

#### FAILURE OF MILK.

ACONITE.—*Anxiety and restlessness.*

BELLADONNA.—*Headache ; congested eyes ; does not sleep well.*

BRYONIA.—*Dry mouth ; constipation (stool large, hard, dry, expelled with difficulty) ; no appetite ; nausea after eating.*

CALCAREA CARB.—*Chilly nature.*

CAUSTICUM.—*Threatened amaurosis ; noises in the ear ; anxiety ; despondency.*

CHAMOMILLA.—*Fretful.*

CHINA.—*Diarrhœa (containing undigested food).*

COFFEA.—*Sleeplessness.*

PHOS. ACID.—*Apathy.*

PULSATILLA.—*Tearful disposition.*

RHUS TOX.—*Want of appetite; mental derangement; powerlessness of lower extremities.*

SULPHUR.—*Cold feet; weak and faint spells; hungry at noon.*

#### GALACTORRHOEA.

ACONITE.—*Anxiety and restlessness; fears she will die; thirst.*

BELLADONNA.—*Headache.*

BRYONIA.—*Thirst and constipation; stitching headache.*

PHOSPHORUS.—*Stitching pains in mammæ.*

SULPHUR.—*Hæmorrhoids; weak and faint spells; hungry at noon.*

RHUS TOX.—*Restless.*

#### AFTER-PAINS.

BELLADONNA.—*Congested head and eyes.*

BRYONIA.—*Headache; dry mouth; thirst for cold water.*

CHAMOMILLA.—*Irritable; thirst.*

CIMICIFUGA.—*Restless; sleepless.*

COFFEA.—*Sleepless.*

CUPRUM AC.—*Cramps in extremities.*

FERRUM.—*Vertigo; headache.*

HYOSCYAMUS.—*Delirium; jerking and twitching in various parts of the body.*

PULSATILLA.—*Tearful disposition.*

RHUS TOX.—*Restlessness at night.*

#### RETENTION OF URINE.

ARNICA.—*Urging to urinate.*

CANTHARIS.—*Great desire to urinate; strangury.*

CAUSTICUM.—*Frequent and urgent desire to urinate.*

NUX VOMICA.—*Painful, ineffectual desire to urinate.*

PULSATILLA.—*Tearful disposition.*

STRAMONIUM.—*Retention of urine.*

#### PHLEGMASIA.

APIS.—*Fever; restlessness; absence of thirst.*

ARNICA.—*Feels bruised.*

ARSENICUM.—*Great restlessness; cold and chilly.*

BELLADONNA.—*Sensation of heaviness in the thighs; cannot bear light or noise; sleeplessness; injected eyeballs; throbbing carotids.*

BRYONIA.—*Dry mouth; thirst.*

KALI C.—Stitching pain in abdomen ; thirst.

NUX VOMICA.—*Loss of appetite ; desire to urinate.*

PULSATILLA.—Clammy taste in mouth ; tearful disposition.

LYCOPodium.—*Rumbling of flatulence in abdomen ; restlessness at night.*

RHUS TOX.—*Restlessness.*

SULPHUR.—*Weak and faint spells ; short sleep.*

#### PUERPERAL MANIA.

ACONITE.—*Fear of death.*

BELLADONNA.—*Sleepless nights ; paroxysms of fury ; desire to hide herself ; merry but quarrelsome ; stupor.*

HYOSCYAMUS.—*Rage.*

KALI C.—*Sadness ; weeps ; thirst ; restlessness.*

PULSATILLA.—*Tearful disposition ; sleeplessness during early part of night.*

STRAMONIUM.—*Fearful and full of strange notions ; face bloated and red ; very loquacious ; visual hallucinations.*

SULPHUR.—*Weak and faint spells ; cold feet.*

#### SORE NIPPLES.

AGARICUS.—*Nipple itches.*

CHAMOMILLA.—*Irritable.*

PULSATILLA.—*Tearful disposition.*

#### ECLAMPSIA.

ACONITE.—*Restlessness ; fear of death ; thirst ; anxiety ; feverishness.*

BELLADONNA.—*Red countenance ; dilated pupils ; difficult deglutition ; foam at the mouth ; involuntary escape of feces and urine ; convulsive movement in limbs and muscles of the face ; pale face.*

BRYONIA.—*Dry mouth ; thirst ; abdominal tenderness ; perspiration.*

CANTHARIS.—*Dysuria.*

HYOSCYAMUS.—*Delirium ; twitching and jerking of the muscles of the body.*

IPECAC.—*Nausea.*

KALI C.—*Eructations.*

LACHESIS.—*Cold feet.*

MERCURIUS.—*Salivation.*

OPIUM.—*Stertorous breathing; redness; swelling; heat of the face; perspiration; sopor.*

PULSATILLA.—*Tearful disposition.*

SECALE C.—*Convulsions.*

STRAMONIUM.—*Puffed and red face; laughter; singing; frightful visions; loss of sensibility.*

#### ACUTE AND CHRONIC METRITIS.

ACONITE.—*Thirst; abdomen tender to the touch; rapid pulse; dry skin.*

APIS MEL.—*Dyspnoea; absence of thirst.*

ARSENICUM.—*Burning pains; great restlessness and anguish.*

BELLADONNA.—*Throbbing headache, with heat; red eyes and face; delirium.*

BRYONIA.—*Headache; nausea; dry mouth; constipation; very thirsty.*

CANTHARIS.—*Frequent and continual desire to urinate, ineffectual, cutting, burning pains, passing only a few drops, which are often mixed with blood.*

CARBO VEG.—*Weariness; flatulence.*

CHAMOMILLA.—*Thirst.*

CHINA.—*Distension of abdomen; diarrhoea; ringing in the ears.*

COCCULUS.—*Paralysis of lower extremities; pulse small; thirst; metallic taste in mouth.*

COLOCYNTH.—*Severe colicky pains; cutting pains in bowels; distension of abdomen; diarrhoea; bitter taste in mouth; great thirst; pulse small.*

CONIUM.—*Vertigo; thirst.*

HEPAR S.—*Chilliness.*

HYOSCYAMUS.—*Jerks of the extremities.*

IPECAC.—*Nausea; rapid pulse.*

KALI C.—*Thirst; cutting pains in abdomen.*

LYCOPodium.—*Rumbling in abdomen.*

MERCURIUS.—*Thirst.*

OPIUM.—*Delirium; flushed face; coldness of extremities; sopor.*

PULSATILLA.—*Tearful disposition; nausea.*

RHUS TOX.—*Restlessness; dry tongue.*

SECALE C.—*Great debility.*

SEPIA.—*Emptiness at pit of stomach; icy-cold feet.*

STRAMONIUM.—*Face bloated; strange fancies.*

SULPHUR.—*Cold feet; weak and faint spells.*

## PRESIDENTIAL ADDRESS.

DELIVERED BY AUG. KORNDORFER, M.D., PHILADELPHIA.

(Read before the Philadelphia County Homœopathic Medical Society, May, 1890.)

*Fellow-members of the Homœopathic Medical Society of the County of Philadelphia :*

PERMIT me to heartily thank you for the compliment which you have bestowed upon me in thus selecting me as your presiding officer for the coming year. I assure you it will be my pleasure to perform whatsoever duties shall devolve upon me in the work of this society, looking singly to the successful issue of every measure which shall be inaugurated for the advancement of our cause.

In return I trust to receive your willing and earnest co-operation. At the close of the year may we feel that its work has been well done and that its results will bear favorable comparison with that heretofore accomplished.

In casting a retrospective glance over our past as a society, we feel impressed with the fact that the year just brought to a close shows in given directions marked advance, when compared with like periods preceding it.

The monthly contributions have been sufficient in number to thoroughly engage the time of the society; they have possessed the merit of being both instructive and interesting, and some may justly claim the additional advantage of offering for consideration original thought and careful investigation.

This holds especially true in the departments of surgery. The articles presented bear evidence that their authors had the courage of their convictions, which led them beyond usual routine practice. Worthy efforts have been made to reach more perfect results through the employment of means and methods in advance of those hitherto in use. Our surgeons have certainly fairly won the honors which they receive. Their untiring efforts and unflagging zeal should act as a stimulus to every physician in our school. Less than three decades ago we had scarcely a single surgeon of ripe experience in our ranks—to-day our surgeons stand in the forefront among the surgeons of the world, in both theoretical knowledge and the technique of their art. This is as it should be; surgery recognized by Hahnemann as a self-evident necessity, though much neglected in

the early days of our school, should reach the most refined development under the stimulus of new ideas generated by the advanced therapeutics of our system. This development should not be in mechanical dexterity alone—intelligent thought and study should be bestowed upon the action of drugs in so-called surgical diseases in order not only that nature might be assisted *without* operation, but that it might thus be assisted to more perfect and speedy restoration *after* operation. Skill in therapeutics should go hand-in-hand with skill in mechanical technique. The latter our surgeons possess most perfectly; let us wish them Godspeed in the development of the former, which less brilliant is nevertheless at least equally important.

We are pleased to observe that progress is also quite manifest in other departments, which offer in every instance favorable comparison with preceding years. In fact, this not only is true so far as our society is concerned, but there appears to be an advance in the journal literature throughout our school. We find unmistakable evidence of a growing disposition to reach beyond a mere surface knowledge of the great truths involved in the teachings of Hahnemann. Unfortunately there is easily to be recognized the prevailing bent of the schools toward a species of eclecticism, which in science is synonymous with imperfect knowledge. But what have we to fear? Nought but *délai*. We remain secure in the fact that law is immutable. Truth is eternal and will most surely survive both the neglect and the misinterpretations of avowed friends as well as the denial and open opposition of its most vindictive enemies. One after another of the forces arrayed against the law must fail and soon sink into oblivion. The mists of error and prejudice which oft cloud the truth from view will be dissipated by the genial warmth of scientific research, leaving the law to shine with renewed light and ever increasing glory.

The present is an age of advancement in every department of human economy. The world appears to be upon the verge of a revolution in both thought and philosophy. Medicine standing as it does in closest relationship to man's physical, yea even to man's spiritual good, must share in proportionate degree in such change. The advocates of law will however have nothing to fear—its opponents will have their strongholds shaken to their very centres. Law will ever continue victorious. The purifying fires of investigation, kept aglow by the efforts of opposition, will burn out every atom of dross, leaving pure golden grains of knowledge for the benefit of future generations.

Such transition and revolutionizing periods not only occur, they are necessary. They arouse and stimulate the interest which so easily flags and develop into activity those latent forces of the human intellect which oft require extraordinary events to quicken them into being.

With each truth discovered, the philosophy of the day is more or less modified; subsequent experiments and observations lead to new developments which, conflicting with former theoretical notions excite, sooner or later, a positive revolution in philosophic thought and reasoning. Higher truths are thus reached; broader and brighter light is thus granted. Thus has it been with homœopathy.

Hahnemann discovered the law under which drugs must be selected for the cure of disease. He also laid down the rule that the quality must be identical with that from which the provings were made. And, finally, that the dose shall be the smallest that will cure. To the first and second of these probably none in our school will raise a dissenting voice. The third involves all the vexed and vexing question of potencies.

This question has, from the earliest days in our history, been argued in a spirit of partisanship, utterly foreign to scientific inquiry.

Though of vital importance it appears as remote from settlement as in the days of Hahnemann. This is largely due to physicians employing more or less exclusively a given potency throughout their practice, forgetting the fact that in every vital act quantity, even though infinitesimal should be considered as an element with quiddity and quality.

That the more highly potentized drugs do act, no one who has had experience in their use can deny. It is equally plain that in the present state of science the limit of drug attenuation cannot be determined. Efforts made upon the basis of the atomic theory must prove futile as the atomic theory itself is but a plausible explanation of certain facts and not by any means so satisfactory in its character as to preclude the possibility of being either greatly modified or even entirely supplanted by a more comprehensive idea of the constitution of matter.

In order to reach more definite results in reference to this question would it not be well for the members of this society to give due consideration thereto, making such reports from time to time as may assist in reaching a solution of the same. Again, in all our investigations we should bear in mind the fact that laws never conflict. Harmony must ever exist. Where this fails, error surely



may be found. The beautiful fancy of "the music of the spheres" has foundation in this sublime harmony existing in the vast universe of matter.

We as a society devoted to the advancement and perfection of the science of medicine, should ever remember this eternal harmony, keep in the van of observers. With a known law to guide, let us make strenuous efforts to develop the therapeutics of our school. To this end the development of our *materia medica* is of paramount importance. The intelligent interpretation of symptoms of both provers and patients is of vital importance. The value of isolated characteristics and so-called keynotes we all recognize, but we must also admit that they are but stepping stones to a better knowledge, a more perfect understanding, of symptoms—a knowledge which would make misunderstanding impossible—I trust that more time and thought will in the future be devoted to this distinctive and extremely useful feature of our work. The medical world demands of us positive knowledge.

We have in times past garnered much rich fruit which we unstintingly supply to all. Our sages, harvesters of past times, are laid away to rest. Who shall worthily fill the places thus left vacant? Who will be the Hering, the Jeanes, the Guernsey, the Dunham, the Farrington of this generation?

I trust the Bureau of *Materia Medica* and that of Clinical Medicine will bestow upon these subjects that consideration which their importance demands. If each society were to furnish but one exhaustive clinical study each year, our *materia medica* would soon be relieved of all superfluous expressions and condensation would soon be systematically and accurately accomplished; a condensation without abridgement of facts or impairment of utility. Then instead of an uncertain and treacherous reading between the lines we would have substituted a clear and comprehensive yet concise pathogenesis written on the lines.

Again, greater efforts should be directed toward the development of a thorough knowledge of the variations manifested in diseased states while under the influence of homœopathic remedies. There is probably no more common complaint among young physicians than that they rarely if ever have charge of a case typically described in the books. To a degree at least this depends upon the fact that cases carefully prescribed for rarely present the grave symptoms often portrayed in the books, while even in the most severe cases distinct modifications result from the treatment em-

ployed. This very interesting field of observation, though best conducted in hospital work, may nevertheless be profitably pursued even in a limited private practice. Dr. Hering used to say homœopathy has developed a new pathology; it will eventually give us a more comprehensive physiology. Especially does this hold good in the study of reflex symptoms.

While thus banded together, laboring for the success of our school through the development of her teachings, good fellowship and fraternal regard will be ripened into bonds of union which will make of our school a power potent for good. Individual differences will be lost in the united desire and effort to fathom truth to its depths, ascend its heights and in broad perspective portray its entire field.

Another and important subject to which I wish to call your attention this evening is that of legislation. This subject has of recent years been pursued by the allopathic school with such singleness of heart and urgency of purpose that we cannot fail to discern an evident desire to gain through some means that supremacy of political power which will give them somewhat the position of State medicine. It behooves us in our corporate as well as in our individual capacity to be ever alert, ready to guard against any act involving injustice to us as a school or to our patients as citizens of this commonwealth. We have in the past experienced marked difficulty in securing ourselves against unjust discrimination in the proposed constitution of the State Board of Medical Examiners. The efforts put forth by the allopaths a few years ago bear out this assertion. The first draft of an act for the purpose of creating such a State board offered our school two seats in a board of seven members. The act further provided that five members should constitute a quorum, and that five votes should be necessary to secure a license. This was so glaringly unjust that it was positively rejected by certain members of your committee. A sub-committee was thereupon appointed to suggest such modifications in the proposed act as would meet the approval of our school. The sub-committee completed its work promptly, but when the modified copy was presented to the society for action it was promptly rejected. Their subsequent efforts in this direction are so recent and fresh in your memories that we need not consume time to more than refer to them. As soon as their last bill was through amendments brought into such shape that harm to us as a school was practically impossible the most ardent workers for the bill withdrew their favor and secured its defeat.

Granting honesty of purpose to our opponents, for as such they

compel us to view them, let us not for one moment delude ourselves with the notion that through them measures would be enacted tending toward the advancement of our school. The more conscientious they are in their own views the more will they be opposed to measures equally favoring ours. Here as everywhere, if we wish to be protected, we must protect ourselves.

Almost every feature of legislation proposed by the allopathic school, both in Europe and in this country, bears the imprint of a species of trades union spirit. They have thus far done but little through legislation for the protection of the public alone. Such measures as have been urged by them in this State for legislative enactment have been so devised as if secured to give them practical possession of the field, which from past experience we feel would not be followed by justice to our school. Let us for a few moments review allopathic legislation as pertaining to homœopathy, so that we may reach a just estimate of the importance of united effort in maintaining the rights granted us by the State.

In 1796 Hahnemann gave to the world the first intimation of his views of the law of cure. Bitter opposition and denunciation was his reward, persecution the early outgrowth. In fact, "the hostility of the apothecaries and physicians of Königsutter drove him from that town in 1799, at which time a law was enacted making it a punishable offense for the physician to dispense his own medicines." Dudgeon in his lectures on homœopathy says, in reference to this period: "Already the hostility of his colleagues began to display itself. Hahnemann who had now abandoned the complicated medication of ordinary practice and who had exposed, though gently, the absurdity of giving complex mixtures of medicines, forbore to write prescriptions and himself gave the medicines, which he now invariably administered singly and alone. The physicians of Königsutter, jealous of the rising fame of the innovator, incited the apothecaries to bring an action against him for interfering with their privileges by dispensing his own medicines. It was in vain Hahnemann appealed to the letter and spirit of the law regulating the apothecaries' business, and argued that their privileges only extended to the compounding of medicines, but that every man and, therefore, still more every medical man had the right to give or sell uncompounded drugs, which were the only things he employed and which he administered, moreover, gratuitously. All in vain. The apothecaries and their allies, his jealous brethren, were too powerful for him, and, contrary to law, justice and common sense, Hahnemann, who had

shown himself master of the apothecaries' art by his learned and laborious pharmaceutical lexicon, was prohibited from dispensing his own simple medicines." Similar proceedings were re-enacted at Leipzig in 1821, in consequence of which he was obliged to give up his practice and retire to the little principality of Anhalt Coethen, where he remained under the patronage of the reigning prince until the year 1835, when he removed to Paris.

What more direct blow against homœopathy could have been delivered than that by which the physician was forbidden to dispense his own medicines, and the patients compelled to procure the drugs from the worst enemies to the system under which the drugs were prescribed.

Their schools in Europe have, in some instances, refused graduation to those of pronounced homœopathic faith. The Massachusetts State Medical Society expelled a number of its members in 1873, because of their connection with the homœopathic school.

By resolution the American Medical Association declared against any of its members aiding or abetting students who proposed to practice homœopathy. They also passed resolutions looking to the establishment of State Boards of Medical Examiners, ignoring in this also physicians of other schools. The most which they have conceded has been a powerless minority (2 in a board of 7—5 a quorum)—(2, 1 h. and 1 ecl., in a board of 9)—(3 in a board of 9)—while they have systematically opposed the creation of separate boards. If they are really in earnest in their frequently expressed desire to protect the people through an elevation of the standard of medical education, let them give evidence of the same by a willingness to strike deeper, so that the very root of the evil may be reached. The law should be so framed as to make it impossible for an incompetent student to pass the final examination. Not only this, but by a compulsory preliminary examination such as fail in educational requirements might be prevented from gaining entrance to the colleges. Guarding the entrance door faithfully would tend greatly to the extinction of the whole evil. All this might readily be attained through the work of a competent board of medical education, such a board to be composed of an equal number of qualified representatives from each school. Members of such a board should possess a knowledge of the educational needs of our colleges, from the literary as well as from the medical standpoint. Such a supervision would prove a wholesome check upon the aspirants to professional honors as well as assist the college authorities in maintaining a high standard

for entrance. By defining the minimum limit for graduation they might secure the desired result before a diploma was granted. This method would also preclude the possibility of any unjust discrimination, either through jealousy or enmity. All colleges would then be subjected to like requirements and like inspection. This idea was suggested to a number of the members of the Legislature during the last efforts made by the allopaths to have a medical examiner's bill passed, and was looked upon by them as being far in advance of the methods proposed by the advocates of the bill then before the House. In order to protect the citizens of one State against the incoming of incompetent doctors from other States provision should be made for the examination of graduates of institutions not subject to similar laws. Graduates from institutions governed by similar State laws should be received without further examination.

In all events the teaching faculties of our colleges are the proper bodies to conduct all such final examinations. To deny this is to argue that our institutions are conducted by men who are either incompetent or untrustworthy, both of which insinuations are false.

Under all circumstances our attention should not be diverted from the essential points in this whole controversy, *i.e.*, first, the elevation of the standard of medical education, and secondly, the protection of the laity against the imposture of incompetent doctors.

We neither require nor do we wish any trades-union protection for ourselves. The allopathic school is organizing all over the country, and will make strenuous efforts to secure the wonted power. The editor of the *Journal of the American Medical Association* claims that more than 70,000 practitioners hold more or less closely to an allegiance with the American Medical Association—a power not to be despised.

Fellow-members: During the past year, with all its progress to encourage us, we have not been without our dark hours of sorrow. Death entered once more, and again has it selected one of our brightest, and noblest, and best. One who, still in the early period of mature experience, gave promise of many years for useful labor in his chosen field. Following what to him was duty's call, he laid down his life a sacrifice for the people. Words offer but a paltry meed of praise for such an one.

The younger members of our profession may find in a life like his an example which it should be their ambition to emulate.

In conclusion, let me urge upon our members, both young and old, the necessity for more regular attendance upon the meetings of

the society. The encouragement of their presence will do more to inspire our Bureaus than aught else could. Let each member feel that it is his duty to come—that his place shall be filled. Each has a right to stay away from our meetings when other duty calls, but each has a duty to be here when possible. Again thanking you for the honor you have conferred upon me, I must beg your lenient consideration in my efforts to preside over your deliberations.

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### SUPRAPUBIC DRAINAGE OF THE BLADDER.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

(Read before the Philadelphia County Medical Society, June 12th, 1890.)

IN connection with the two papers on suprapubic lithotomy presented to-night, I have thought it might not be out of place to direct attention to epicystotomy as a means of more or less permanently draining the bladder. I do this especially with the hope that this method of diverting the flow of urine from its ordinary channel, may be borne in mind in the treatment of that large class of cases, particularly old men, whose entrance upon so called "catheter life" is but too often the beginning of a very near end.

My personal experience with this operation for the purpose of establishing an artificial urethra is limited to two cases, one of which is of too recent date to be of value. The history of the other is briefly as follows :

Mr. T. E. W., age 55 years, was sent me early last summer by Dr. Rembaugh. His symptoms then were those of an aggravated cystitis, with an abundance of pus, quite profuse hæmorrhages, frequent urination (every fifteen minutes, day and night), dysuria and cystic pain. The prostate was enlarged, a projecting middle lobe being also made out, as well as the trabeculæ of an eccentric hypertrophy of the vesical wall. No stone or tumor could be felt. The cystoscope showed intense congestion of the mucous membrane. Careful and persistent washing, appropriate medication and the use of the catheter did no good, the latter causing such pain and irritation that it could not have been available much longer. The expression was anxious and pinched and the man plainly failing from week to week. Suprapubic exploration and possible permanent fistula was suggested and eagerly accepted.

The operation was performed at the Hahnemann Hospital, August

27, 1889, with the usual precautions. The technique will be referred to later on. The mucous membrane was found to be soft and mushy and bled easily; the lateral prostatic lobes were uniformly and considerably enlarged and the middle lobe formed a distinct projection; the soft catheter passed around this while the staff pushed it back. It was readily removed with *rongeur* forceps; the hæmorrhage was moderate. A T-shaped tube served for drainage, around which the tissues were closely united by catgut. The after-treatment consisted of irrigation by the urethra three times daily. On the second day there was a chill and rise of temperature; the tube was removed, irrigation practiced hourly and the wound partially opened later on. After this recovery was uninterrupted.

The urine gradually cleared up and has remained normal ever since; there has been no recurrence of the hæmaturia; urination became less and less frequent and entirely free from pain until now he passes water every two or three hours during the day and less frequently at night. He wore a catheter and canula until December, since which time he has drawn his urine through the fistula when the bladder feels distended. The fistula never leaks nor can he force any urine out of it. He occasionally urinates through the urethra, at night when he is too sleepy to use the catheter, or when the bladder gets very full and he feels the sudden and irresistible urging so characteristic in prostatic enlargements. He cannot however completely empty the viscus on account of the bilateral hypertrophy of the prostate, and will not, consequently, listen to any attempt at closing the fistula. On one occasion, when this was plugged experimentally for several days, the residual urine set up a cystitis with a recurrence of his old pain. Strange to say the sexual function has been revived and renewed. He has resumed his work which he had been obliged to give up. Within a few weeks a hernia appears to be developing in the cicatrix above the fistula.

This case is an example of a method of treatment first systematically advocated, so far as I know, by Hunter McGuire. In the *Transactions* of the American Surgical Association (Vol. VI., 1888) he reports his first case and supplements this with several more in the *Medical News* (May 17th, 1890).

The operation presents undoubted advantages over the other methods in vogue.

Perineal section, digital exploration and drainage by a tube has been earnestly advocated and extensively practiced by Sir Henry Thompson, but even he seems, more recently, to be gravitating towards the suprapubic route. In my experience, and I think that I voice that of a goodly number of surgeons, if not the majority, the perineal tube is excessively painful, cannot be worn long and, when removed, the drainage ceases. Digital exploration of the

bladder is possible if the perineum be not very deep, but cannot be aided by inspection. Operative procedures for tumor, prostatic enlargements, or the removal of unexpected calculi must necessarily be more or less hampered by the lack of working space, and parts are stretched and roughly handled, a tearing of which may lead to disastrous results. To my mind these drawbacks more than counterbalance the dependent drainage, and this too is often *not* dependent, if, for example, a prostatic hypertrophy be present.

On the other hand the suprapubic route is the one to fall back on when all others fail and seems to-day to be fast making a record which will permit of its being called the point of election. By it anything removable can be removed, digital exploration is as thorough and as easy as possible, and inspection can be made of every corner with the aid of an electric lamp or head mirror and Trendelenburg's cystic or pelvic Sim's position. Drainage furthermore is *continuous* and *complete*, with or without a tube, and without the necessity of the prone position. I have never met with a suprapubic fistula that refused to heal; in fact the trouble has been to keep the opening patulous long enough. This was so in the case just reported. Even should such a fistula persist it cannot, to my mind, be more annoying and obstinate than those I have met with in the perineum. It cannot, furthermore, interfere with the sexual function, as does at times the perineal section. McGuire and others who have practiced his method have found that the urine can be thrown several feet from an artificial suprapubic urethra. In my own case, while the fistula does not accomplish this, "catheter life" is carried on without irritating the sensitive deep urethra and without the consequent dangers and complications so familiar to every one. In point of fact, it had been found in this case that the continuous use of the catheter would be impossible: One disadvantage I must record, and this especially as it is an unusual sequela, the development of the hernia in the cicatrix above the fistula. I have no doubt that had I been able to leave the wound closely sutured layer by layer around the tube this might have been avoided. It can be readily controlled by a truss.

As to the other methods, rectal puncture, to say the least, can never be of service for any length of time. For temporary relief it has long been superseded by suprapubic aspiration which can be repeated indefinitely. Harrison's perineo-prostatic puncture does not seem to have met with favor, and, while it drains for a length of time, it allows of no exploration.



Suprapubic permanent puncture, as recommended and practiced by Dittel, has some advocates, but I must confess to a strong prejudice against it. It has drainage and the point of election in its favor, but urinary infiltration certainly takes place alongside the canula at times and there is no wound to open and give free vent. I saw several deaths in succession in Dittel's wards, and met with a similar result in the one case in which I have tried it. The patient was an old man with enormously distended bladder, tight stricture, and very large prostate. The puncture and *slow* evacuation gave temporary relief, but infiltration followed. In urgent cases I have usually aspirated when no instrument could be *coaxed* into the bladder, and, in a similar case, would practice this and follow it by epicystotomy and an artificial urethra. Or better, an incision is made down to the bladder under cocaine anæsthesia, the urine slowly drawn off with the aspirator and the opening made at once or later on, as is deemed advisable. In this way urinary infiltration would be out of the question.

The removal of portions of the prostate has hitherto been very fatal in its results. McGill, of Leeds, in a recent article, has made an earnest plea for the procedure and recorded very satisfactory results from his own practice and that of his colleagues. I have on three occasions twisted or cut off a prominent middle lobe without much hæmorrhage and without after complications. I should hesitate, however, to practice removal of lateral lobes unless they presented a distinct, projecting, or more or less pedunculated tumor. In the three cases mentioned the lateral lobes were uniformly and considerably enlarged and while the removal of the prominent middle lobe did away with the major symptoms, in one instance permitting an uninterrupted flow of urine, and in the other rendering voluntary urination possible for the first time in many years, residual urine still remained and the annoyance caused thereby continued in a modified degree.

As to the technique, it may not be out of place to refer to a few points, as I have used much the same method in all my epicystotomies.

(1) *Position*.—The buttocks are raised by a firm pillow, the head of the table is lowered, and, for inspection, this is exaggerated by an assistant, who raises the pelvis with the limbs over his shoulders, or, in a child, by inverting the body. These precautions cause the abdominal contents to gravitate toward the diaphragm and tend to keep the peritoneal fold out of harm's way; further elevation, after

the bladder is opened, causes its distention with air, like the vagina in the well known Sim's position. If available Trendelenburg's table will be useful. I might add here that I have used this position, as suggested by Trendelenburg (*Sammlung Klinischer Vorträge*, No. 355), in abdominal sections for pelvic troubles with much satisfaction. In one instance I was able at once to detect and arrest a severe hæmorrhage deep in the pelvis; previously I had been obliged to lose time and run risks by evisceration. (2) *Distension of the Bladder and Petersen's Bag*.—I have always used the former, after thoroughly washing, carefully injecting from six to ten ounces. Extreme care is necessary in cases of contracted or much diseased bladders. Petersen's bag has been much extolled and used. A. B. Strong (*Annals of Surgery*, January, 1888) has shown by experiments on the cadaver that it has more to do with raising the bladder, and particularly the peritoneal fold, than the intravesical injection. Braun's Colpeurynter or Barnes's Dilators make very good substitutes for the Petersen bag. Its careless use has resulted in serious accidents on some occasions, so that I have come to depend upon it less and less. In children in whom we would expect a low dip of the peritoneum I always use it, but in adults it seems to be of minor importance. I have never wounded the peritoneum, nor should I particularly dread doing so. If the pelvis is well raised, the head and shoulders depressed, and the steps to be described are followed, there seems to be little danger of such an accident. (3) *Incision*.—This is best made in the linea alba, just as in a median laparotomy, about three inches in length and down on to the pubic symphysis; it may advantageously be supplemented by transverse separation of the muscles from the bone in powerful subjects, in incomplete anæsthesia, or if much room is desired. The prævesical fat is then to be rolled up with the finger, aided by a few touches of the scalpel, to avoid laceration, and with it the peritoneal pocket, until the bladder-wall proper is reached. In finding the latter the operator is much aided by (4) *The Staff*, with or without a groove on its upper aspect, and hollow or solid, over the beak of which the tissues can be rolled until it is certain that nothing intervenes but the vesical wall. In fact, when this is reached, the tip of the instrument can be distinctly seen. (5) *Opening the Bladder*.—This should be preceded by passing a loop of silk at the top of the proposed incision to steady the wall. A tenaculum is apt to slip off, and I have found this loop a handy guide in re-entering the cavity, introducing instruments, etc. The incision can then be made on the point of the staff and along its groove. One word of caution

may not be out of place here. The assistant should hold the staff *absolutely* still. It happened to me a short time since that, after cutting down on the point of the instrument its beak turned and I lost the small opening. As a result the bladder was punctured twice. The finger should at once follow the knife and explore the distended viscus. I have found that an empty bladder will contract quite forcibly on the finger, and cannot of necessity be as thoroughly explored as one that is partly filled. Manipulations and inspection can be materially aided by grasping the edges of the vesical wound with artery clips or T-forceps, and drawing them out and apart. (6) *Closure, drainage and after-treatment.*—It has been my custom to drain the bladder with the T-shaped tube for from a few hours to three or four days according to the annoyance it may cause. The inlying catheter is unnecessary as the organ empties itself *completely* through the wound. This is closed around the tube layer by layer, more and more loosely, forming a funnel into which iodoform gauze is lightly packed. A rise of temperature calls for removal of the tube, frequent irrigation through the urethra, and, if necessary, removal of the stitches. If no amelioration follow I have, in one instance, kept a stream of borated water running continuously for twenty-four hours through a catheter in the urethra, into the bladder and out of the hypogastric wound. This washed out every drop of urine as it came down from the ureters and had the desired effect.

Of course in young subjects or healthy bladder-walls that have not been roughly handled, if drainage is not desired, immediate or secondary suture is indicated.

There is one result of epicystotomy on which I do not think sufficient stress has been held—its influence on hæmaturia. I have met with two cases in my own practice and have seen a number in other hands, where a persistent hæmaturia was so associated with cystic symptoms as to call for an exploratory epicystotomy, at least as a preliminary step. Nothing was found beyond a possible varicosis of the bladder but the bleeding invariably stopped and this whether or not drainage was employed. This seems to be somewhat analogous to the benefit following abdominal section for growths that cannot be removed.

In conclusion I would heartily endorse epicystotomy: (1) In exploration, as giving the easiest access and the best means of subsequent operative work if needed. (2) For drainage, temporary, where it compares favorably with the perineal section, or to form

the best possible artificial urethra. (3) As the method *par excellence* for the removal of growths, prostatic or neoplasms, and as *the cutting* operation for stone, if not *the* operation for stone in the hands of the average surgeon, one who is not trained in urethral and vesical manipulations.

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#### NOTES ON ORIFICIAL SURGERY.

BY C. H. GOODMAN, M.D., ST. LOUIS, MO.

IT is only by after observation of cases operated on orificially that one can fully comprehend the results and wide-reaching effects of this system of treatment in the most inveterate maladies. One has but to visit the new Lincoln Park Sanitarium recently opened in Chicago to find every facility afforded for seeing operative and post-operative measures, as well as to learn the range of diseases belonging to this class of work. The institution is worthy of its cause, lacking nothing in the way of location or appointments to contribute to the rapid recovery of its inmates. A recent visit affords a few items which may be of service to those interested in orificial work. It is to be noted that Prof. Pratt no longer favors wet applications in the after-treatment of rectal operations—dry ones being preferred. This is a departure from the rule given in his clinics and class teaching in the past. That in all reflex disorders of the sexual system, due to rectal irritation, subcutaneous section of the rectal sphincter is to be made. That subsequent trimming after the Pratt operation and nicking or division at intervals of the cicatrix and a sound dilatation is an important measure not to be overlooked in after-treatment. That enemata of milk, with or without pepsin make an excellent douche for intestinal flushing on account of the bland and nutrient qualities of the fluid. That a case of anasarca with mitral insufficiency, unable to lie down in bed, once tapped, with a face the picture of despair, showed marked signs of relief in respiration and diminution of the deposit in the limbs, in two days after dilatation of the uterine cervix with sounds, a previous laceration having been operated on by another attendant without complete removal of the cicatricial plug. It is expected that following this more thorough operation a rapid recovery will ensue. That a case of so-called leucocythemia which had been in the hands of several eminent allopaths and as variously diagnosed, with atonic discharges profuse and offensive to an extreme degree and with most profound

anæmia, was rapidly regaining health after the Pratt operation, with visible signs of color in a skin as white as a sheet. That orificial surgery relieved a hæmorrhagic condition of the gums which had existed a long time and was so profuse as to fill the mouth with blood several times a day, and with this disappearance came a decided improvement in hearing, which had been much impaired. Dr. Hubbard, of Marion, Iowa, reported at the sanitarium a new hæmostatic dressing in the ordinary white silk handkerchief in daily use. In an operation for hypospadias at this place, the efficacy of the dressing and its hæmostatic qualities were most forcibly demonstrated. On account of the hæmorrhage, the previous operative measures had not been entirely successful, stitches having to be removed to check the loss of blood and thus not securing perfect coaptation of the parts. The same condition recurring again, an application by simple pressure of a white silk handkerchief to the cut surface rapidly and permanently checked the hæmorrhage. Subsequently, as a dressing, a bandage of the same material was applied, about three inches in width, the outer edge being turned in to avoid loose threads about the cut surface, and then secured by a silk thread. Dr. Hubbard claims, in his experience, it is far superior to any dressing he has ever used. It possesses three most desirable qualities: that it absorbs water as readily as a sponge and can be removed almost painlessly from a wound, and it can remain longer as a dressing and does not grow hard like the ordinary bandages in use, and is light and cool. The suggestion is original and novel, and in this case certainly gave evidence of its value.

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#### THE ALLOPATHIC STATE CONFERENCE AND HOMŒOPATHY.

BY C. NEIDHARD, M.D., PHILADELPHIA.

DURING the Allopathic State Conference, Professor John H. Packard read a paper on the proposed bill creating a State Board of Examiners. He said he did not endorse the proposed law, because it would create a board of six regular physicians and three homœopaths to license practitioners.

Hence, under that arrangement, the laity would take it as granted that homœopathy, eclecticism, Thompsonianism and other pathies are safe.

In order to confuse the mind of the laity, he mentions eclecticism, Thompsonianism and other pathies in conjunction with homœopathy, although he must know that some of the most distinguished old-school physicians acknowledge the truth of the homœopathic law, at least in some cases.

Dr. Dudgeon, of London, has shown by liberal quotation from the work of the Medical Examiner of *Materia Medica*, of London University, that he uses the same indications of remedies in numberless cases, although he does not credit it to the source from which he derived his knowledge.\*

The idea becomes clearer and clearer, even to the most benighted individuals of the ancient system, that true and lasting cures can only be performed by remedies acting on the homœopathic principle.

There is also a work by Dr. Bartholow where the same dishonest method is pursued. He gives the homœopathic indications of his remedies on one page and on the next he calls them quacks. Can this dishonest mode of examination be any longer tolerated? We trust not. After all, without a thorough study of the homœopathic *materia medica* the regular physician, as he calls himself, will only be a bungler. Professor Horatio Wood is also opposed to the bill for creating a State Board of Examiners, saying: "Our diploma does not prevent John Smith being a homœopath, scoundrel or other unseemly thing." What that is, no one knows. Another physician had the impudence to say, that if a homœopathic physician knew more about anatomy, physiology, surgery and the other branches of medicine, he would not be a homœopath, although perfectly aware that the curriculum of the studies in homœopathic colleges is exactly the same as in the old-school colleges and universities.

This contemptible way of treating homœopathic practitioners is carried on with the object of making innocent laymen believe that they care very little about this homœopathy, although they are not able to conceal their rage about its constant progress. They know from statistical tables of homœopathic hospitals that the mortality there is only one-half or one-third of what it is in the other hospitals; they also know very well that the practitioners of the new school are as well educated as those of the old school, and its advocates are among the most intelligent and independent thinkers of the community.

Let these owls alone, and they will shrink back into the darkness of their holes.

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\* "At last the Royal College of Physicians converted to homœopathy."

## EXAMPLES OF HOMŒOPATHIC CURES.

BY MILLIE J. CHAPMAN, M.D., PITTSBURGH, PA.

(Read before the American Institute of Homœopathy.)

LAST year you listened to able papers upon Preventive Measures and Medicine. To-day I present cases which were not fortunate enough to receive the care outlined in those papers, and disease claimed them as victims. Through good nursing and the influence of homœopathic medicines they were restored to normal health.

CASE 1.—John —, aged six years. Child of feeble mind; his father highly intemperate; his mother an intelligent, industrious woman died of phthisis while the child was under my care. Two older children, who were in fair health and of average mental strength, were meeting the struggle common to children of such families. In January, 1889, I was summoned to attend John. He had from one to six epileptic convulsions in twenty-four hours, occurring mostly at night, although sometimes they came in daylight. During the interval between attacks he was in the condition of one with well-developed chorea. Movements so violent that to prevent injury to himself the sides of his crib were padded, his hands bandaged, and often it was necessary to fasten a sheet over the top of his deep bed to keep him within. Action of his bowels and bladder was involuntary. To feed an acrobat while displaying his skill would have been ease compared to giving John a meal. The moans, growls and piercing shrieks he uttered at times made him an undesirable inmate of any house. After many wanderings, he was admitted to the children's ward of the Pittsburgh Homœopathic Hospital. His diet for some time was milk, Mellin's food or oatmeal gruel. Baths were necessarily given, daily at first. Remedies were varied, and with apparently no effect until *bufo ran.* 30x was given, every four hours for a time; later, only night and morning as improvement set in. At the end of six months he could feed himself; say many words of one syllable; sit, stand and walk like any child of his age; was interested in the plays of other children in the ward, or as they were taken by the nurse for an airing. He had no convulsions for three months. He was then removed to another home, where he has had a continuance of health, with great awakening and development of mental faculties.

The influence of heredity has been well considered. In no branch is it more important than the conditions which result in urinary disturbances.

Prout says: "Children of dyspeptic or gouty individuals inherit

a tendency to urinary affections. They are exceedingly liable to crystallized lithiac deposits from the urine."

Budd and Murchison claim that brain toilers beget children who retain the uric acid formation of early childhood beyond the period of puberty, when it ordinarily ceases. Fothergill states that brain work not only injures the viscera of the individual, but handicaps his offspring. Such workers predispose their children to lithiasis. What is acquired by the father is inherited by his progeny. With these facts in view we are prepared to understand that the following case should be a sufferer.

CASE 2.—Elmer —, whose father is a clergyman with a large parish, and is always overworked; dyspeptic, rheumatic, had twice suffered removal of vesical calculus. The mother was of frail health, but enduring and long-suffering. She could not nourish her child, hence he was a bottle-fed baby. He was apparently well the first week of his life. About this time, the red sand in the diaper was first observed. From this time, there were evidences of urinary disturbances. His clothing was often stained a dark orange; crying on voiding urine; an excessive secretion or a partial suppression, with the varied moods of lamentation or peaceful states which would naturally attend these conditions; appetite, feeble; indigestion on the slightest provocation.

At the age of one year, although strumous in appearance, he was an interesting child. He took cold easily, and after one exposure had oedema about the eyes, both above and below, with an almost transparent skin. The scrotum greatly enlarged with fluid. For months, with every indisposition, there was a tendency to a return of this condition. Twice he had convulsions which were supposed to be caused by oedema making cerebral pressure. With judicious nursing and the skill I've been able to summon in the administration of remedies, this patient is rapidly approaching a desirable state of health. An important element has been the frequent salt baths; the regular outings from which he has become accustomed to outside atmosphere in either clouds or sunshine; the reasonable clothing so made that the warmth was equal on trunk and limbs. He still wears the ribbed elastic woollen bandage; an essential for every child from birth through dentition, except where umbilical hernia requires a firmer pressure. As every attempt at eating meat or even taking beef-tea or broths is followed by an abnormal condition of the urine, he lives upon bread and milk, eggs and vegetables.

Apis mel., kali carb., calc. carb., lyco., nat. sulph. and ars. alb. have, at various times, been serviceable. While no remedy produced a sudden cure, the action of each was marked and relieved the symptoms and suffering at the time given. The system has been so changed by these remedies, that now health and its influences are



realized where, otherwise, the excess of uric acid and lithiac deposits would have crippled youth and even adult life.

CASE 3.—N. S., aged five months, had been a victim of artificial food, and hence a sufferer. He was treated heroically for marasmus, until a pillar of the dominant school was called, who diagnosed diabetes. In accordance with a writer in a recent standard work on diseases of children, he gave a prognosis of an early fatal termination. At this, the parents sought homœopathic treatment. The prominent symptoms were emaciation, pale face, eyes sunken and lustreless, difficult breathing; abdomen, hard and painful to touch; urine, profuse and ammoniacal; dry, cold skin, and he gave evidence of pain and nausea after taking food.

The prescription was iodine.

The diet, one teaspoonful of cream every two hours for a week, then milk in greater quantities.

Improvement was noticed in twenty-one hours, and at the end of twenty-one days he was a vigorous child. Should his present health continue as many years, he will be able to understand the law of similars.

In fact, he may even administer the same remedy to some of his early attendants for a morbid lymphatic system which, in its incipient stage, produced a sluggish brain, resulting in the cruel treatment he received.

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## A METHOD FOR RECORDING URINARY ANALYSES FOR CLINICAL PURPOSES.

BY CLIFFORD MITCHELL, M.D., CHICAGO, ILL.

IN order that urinary analyses may be of clinical value, much depends on the method in which the record is kept. I suggest that some particular system of recording the analyses be rigidly adhered to so that comparisons may be made readily, and with comparative accuracy. The following is the method which I greatly prefer to all others. The results may be compared with normal by reference to my *Tables*, a copy of which I shall be glad to send gratis to any one sending postage:

### *Record of Examination of Urine.*

Volume of urine in 24 hours, .....  
    what per cent. of normal, .....  
Volume of day urine, .....

Volume of night urine, .....	
Ratio of day urine to night urine, .....	
what per cent. of normal, .....	
Total nitrogen, .....	
Urea, { grammes per liter, .....	
grains per fluid ounce, .....	
what per cent. of normal, .....	
Urea, { grammes per 24 hours, .....	
grains per 24 hours, .....	
what per cent. of normal, .....	
Phosphoric acid, { grammes per liter, .....	
grains per fluid ounce, .....	
what per cent. of normal, .....	
Phosphoric acid, { grammes per 24 hours, .....	
grains per 24 hours, .....	
what per cent. of normal, .....	
Uric acid, { grammes per liter, .....	
grains per fluid ounce, .....	
what per cent. of normal, .....	
Uric acid, { grammes per 24 hours, .....	
grains per 24 hours, .....	
what per cent. of normal, .....	
Total solids (approximately by Trapp's coefficient, .....	
what per cent. of normal, .....	
Total salts (i.e., solids less urea), .....	
Ratio of total urea to total salts, .....	
what per cent. of normal, .....	
Ratio of urea to phosphoric acid, .....	
what per cent. of normal, .....	
Ratio of urea to uric acid, .....	
what per cent. of normal, .....	
Any marked variations in quantity of chlorides, sulphates, coloring-matter, etc., .....	
Physical characters of the urine:	
Color, .....	Odor, .....
Specific gravity, .....	Reaction, .....
Acidity (as shown by number of drops of liquor potassæ required to neutralize', .....	
Acidity, compared with normal, .....	
Appearance of the urine, .....	
Abnormal constituents (sugar, albumen, etc.), which are present, .....	
Abnormal constituents, { grammes per litre, .....	
grains per fluid ounce, .....	
Abnormal constituents, { grammes per 24 hours, .....	
grains per 24 hours, .....	
Abnormal coloring matter (blood, bile, etc.), which are present, .....	
Results of special tests,—the ferric chloride reaction, the diazo reaction, etc., .....	

The urinary sediment,—volume, compared roughly with that of the urine, .....

.....

Color, ..... Character, .....

Constituents,—amorphous substances, .....

Crystalline substances, .....

Epithelial cells, .....

Corpuscles, .....

Tube casts, quantity, ..... Size, .....

Variety, .....

Micro-organisms, .....

Miscellaneous, .....

.....

Summary of the chief points brought out by the examination, .....

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.....

.....

(Signature.)

**NIGHTMARE IN ASSOCIATION WITH INFLUENZA.**—A blonde girl, aged nine years, of lively disposition and mentally well-organized, passed through a severe attack of influenza. During the stage of convalescence, she screamed out in sleep, "Father, I grow, I become an animal, I am steadily enlarging, hold me!" Her father did his best to pacify her, and though fully awake and aware of the fact that it was but a delusion, she feared to go asleep again for sometime. An old gentleman, who had likewise gone through an attack of "*la grippe*," said that at the acme of the attack he felt in his sleep as if he was losing the human form and was being changed into a plant.—*Med. Neuigkeiten*, 15, 1890.

**SYPHILITIC DISEASES OF THE CENTRAL NERVOUS SYSTEM.**—The usual form of cerebral syphilis consists of a diffuse gummatous meningitis basilaris. The pathological process is especially to be seen in the interpeduncular space and around the chiasma. The base of the brain is covered with a tough fluid which penetrates into all furrows and covers the origin of many of the cranial nerves. This new tissue, rich in cells and bloodvessels, soon becomes hardened and compresses the neighboring nerves and bloodvessels, the former of which then take on atrophy, especially the optic and the oculo-motor nerves. The walls of the bloodvessels show thickening and small cell infiltration, thus narrowing their calibre and causing thrombotic occlusion. The disease sets in with general manifestations, as headache, vertigo, vomiting, syncope and spasms. The mental faculties become weakened. There may occur occasional loss of consciousness or mental deterioration, as mania, acute dementia, etc. Occasionally the olfactory, the fifth and the eighth cranial nerves may be involved, though, as above stated, the second and third pairs are the ones most frequently affected.

Characteristics of the specific nature of the disease are its afebrile course, the fugitive character of the symptoms (they come and go); the granulation tissue is short lived; it proliferates, dies and grows afresh, so that the nerves surrounded by it are exposed to variations of pressure not observed in any other disease. In advanced stages we meet with one-sided paralysis due to vascular disease.

In the case of syphilitic meningitis affecting the convexity, the symptoms are not so characteristic of syphilis, the only hint of the true nature of the trouble being the fluctuating severity of the symptoms.

The syphilitic process rarely involves the spinal cord alone. Usually the brain is simultaneously affected. Here also the meninges are especially diseased and the cord is enveloped in a gummatous neoplasm. Syphilitic cerebro-spinal meningitis is one of the most frequently met with syphilitic diseases of the central nervous system. Its prognosis is more doubtful than is that of meningitis involving the brain alone.—*Allgem. Med. Centr. Zeitung*, 51, 1890.

## EDITORIAL.

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### MEDICAL LEGISLATION.

IN obedience to the command of the American Medical Association, the allopathic physicians of Pennsylvania have had a gathering of the chiefs of their county clans at Bedford Springs, Pa., to map out their medical legislation campaign for the coming winter. Under the specious plea of seeking the advancement of public interests *only*, they will demand the establishment of a single State board of medical examiners and licensers composed entirely of allopathic physicians; failing to secure a board of this character, they will accept a board of mixed membership, provided they are given an overwhelming majority of the members, creating in them a vicious monopoly of medical licensure. That the allopathic school is really governed by ulterior motives and is seeking unjust results, goes without question. Dr. D. B. St. John Roosa, the Chairman of the Committee on Legislation, of the New York State Allopathic Medical Society, stated, in a public speech, that "the single board system once established, sect in medicine will soon be practically destroyed." He was not choice in the selection of words, but honestly and emphatically declared that the real object of their frantic attempts to secure single examining boards to be for the purpose of *destroying sects in medicine*, particularly homœopathy. No matter how desirable medical unity may be, it will never be accomplished on the St. John Roosa basis.

The homœopathic school has declared itself opposed to restrictive legislation which tends to curtail civil rights, encroach upon personal liberty and check the progress of medical science. The school is in favor of an advanced standard of preliminary education, the highest and broadest possible curriculum of medical study, the extension of the lecture term from six to nine months of continuous instruction in each year and the adoption of four years of medical study preparatory to graduation. When it becomes necessary to accept a medical license board, the homœopathic profession will do so in one of two ways; either a single board must be so constituted that each system of medicine be equally represented, or if this is not acceptable to the allopathic school, then separate boards must be created for each school of practice. More than this, the homœopathists do not want, and they will certainly never submit to less. The school does not

object to allopathists having exclusive control of allopathic examining boards, but it will not tolerate any interference with its civil liberty, and any attempt on the part of the allopathic school to control the examination and the admission of homœopathic students into the medical profession will be resisted to the fullest extent. Homœopathists demand the legal right to license their own students. The claim that the allopathic school, representing the largest number of practitioners in this country, should, on that account, assume the entire control of medical licensure, is an utter absurdity arising from the intensity of intolerant prejudice. The right of medical licensure constitutes a civil privilege. The law, recognizing three distinct schools or systems of medicine, the free exercise of this privilege belongs properly to the representatives of one school as freely as it does to another. Legal rights and privileges are not increased or diminished in proportion to the ratio of membership; all schools and systems are regarded, in the eye of the law, as equal and similar in every respect. We could as reasonably say that the Methodists, being the greatest in number, should, on that account, claim the exclusive civil right to license and ordain Episcopal or Roman priests, and appoint the pastors of Baptist churches, etc. Homœopathists fully recognize their rights and, notwithstanding the united and overwhelming force of the allopathists for a single board, it is to be distinctly understood that the new school does not want, nor will it accept a minority representation upon a board *controlled* by the old school, unless that minority has absolute and full control of examining and licensing *all* homœopathic applicants. We are confident that if in the future a license is to be the test of medical attainments instead of a diploma, the discerning and enlightened legislature of Pennsylvania will concede to the homœopathic school the just right of the *exclusive control of its own members*.

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#### HOMŒOPATHY AND THE INSURANCE COMPANIES.

OF late considerable discussion has been aroused by the discrimination made by certain life insurance companies against homœopathic physicians as examiners. The Nebraska State Society first, and later the American Institute of Homœopathy and various State and local organizations all over the country, have appointed committees for the agitation of the question. Investigations made reveal

the fact that the vast majority of the so-called big companies discriminate against homœopathic physicians to such an extent as to positively prohibit their appointment as such. It does not appear that the business management of these companies is directly responsible for such a state of affairs; but rather that the appointments of local examiners are made by a chief medical examiner appointed by the company, said chief being in every instance an allopathic physician, who, of course would not, under any circumstances, give a homœopath an appointment. The allegation for the justice of such action was stated by one of these in a letter to Dr. Cowperthwaite, to be the fact (?) that homœopathic physicians are not taught and consequently are not skilled in physical diagnosis.

When this question was first agitated, it seemed to us as it did to others, that it were better let alone. Apparently, it was an undignified scramble after salaried offices. This opinion we did not hold after further thought. We can well remember the question often put to homœopathic physicians by their lay friends: "How is it, if homœopathic physicians are well educated in all branches of medicine, that their abilities are not thought sufficiently of by insurance companies, to secure their appointments on their examining staffs?" The question is not therefore one of spoils, but one of principle. A stigma has been placed upon the diagnostic abilities of homœopathic physicians by a large moneyed interest of the country. It is not that we want the appointments, but the eligibility to election to such. That homœopathic physicians are competent to fill them creditably and profitably to the companies none acquainted with the facts will deny. The instruction in physical diagnosis in our colleges is far ahead of that of allopathic institutions. So far as the medical examinations are in many instances concerned, and we speak in full knowledge of the facts, we would say that many of the examinations made by the allopathic examiners are of such a perfunctory order as to disgrace even a mechanical-physical-examination-accompaniment to a twenty-five-cent-office-prescription, their actual value being worth about that, and nothing more.

We trust, therefore, that homœopathic societies will continue the agitation thus begun until the unjust discrimination has been removed. While it is not unlikely that the vast majority of our men having the ability will find a more profitable avenue for the employment of their talents, still it is not pleasant to feel one's self ineligible to an office occupied by a man greatly one's inferior.

## THE DECLINE OF EMMET'S OPERATION.

THE operation for repair of laceration of the cervix uteri which was so much in vogue but a few years ago has not of late been performed with its former frequency, probably because its proper sphere of usefulness is now well defined. It would now *seem* that the operation has received its death-blow since Mr. Lawson Tait has taken the opportunity to denounce the procedure as "one of the most useless ever introduced into surgical practice." As obedience to Mr. Tait's *ipse dixit* is now as fashionable as was once the operation which he denounces, it would seem that there is danger of going to the extreme of abandoning an operation which, when performed by a judicious surgeon on proper indications, has done much to alleviate the sufferings of women. Mr. Tait claims that the real trouble is in the subinvolution and consequent chronic metritis, and that the tear is not of the slightest consequence. We think that many gynecologists will bear us out when we say that the repair of the laceration will often bring about proper involution after all other measures have proved futile.

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## "HE CHANGED HIS TUNE."

THE daily papers, a few weeks ago, in reporting the meeting of the Michigan State Medical (Allopathic) Society, credited the president thereof with saying, in his annual address, that homœopathsists were quacks and impostors. Of course, such a statement raised quite considerable indignation. President Frothingham thereupon took occasion to deny having made any such assertion. He had merely wished to denounce medical sectarianism. There was a time when allopathists were proud of their bigotry; had the daily press credited one of them with making remarks defamatory of homœopathsists, he would have delighted in the notoriety thus gained. But now, things are changed; and public sentiment must be respected.

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## THE "LANCET'S" LIBERALISM.

THE editors of the London *Lancet*,\* in a recent editorial, say: "The day is probably not very remote when persecution, ostracism or censure for differences of opinion or belief will be regarded as not

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\* The *Lancet*, June 28, 1890.

only immoral but absurd." If St. John Roosa and his kin will use their best endeavor to hasten the coming of this day and join the *Lancet* writers in showing their brethren the ludicrous folly of attempting to compel a man to change his belief by force, and point out that conviction based on reason can only be attacked legitimately by reasoning, the day of professional unity will be at hand.

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THOMAS NICHOL, M.D., LL.D., D.C.L.

FROM the *N. E. Medical Gazette*, for August, we learn the sad news that Dr. Thomas Nichol, of Montreal, Canada, is no more. Dr. Nichol took an active interest in all matters relating to homœopathy. His writing had gained for him a world-wide reputation. He was one of the few physicians who have been honored by the Homœopathic Medical Society of the State of Pennsylvania with an election to corresponding membership, a testimonial to his rare worth as an author and a physician.

To those who met Dr. Nichol during his recent visit to Philadelphia, the news of his death comes as a great shock. The Doctor was not in the best of health at that time; but with the great care he was then taking and the prolonged rest, it was thought that the worst was over. He spoke of revisiting us in another year, a visit which we, as well as he, looked forward to with pleasure.

Very few men studied as did Dr. Nichol; few appreciated as did he, the value of a large library. As great as his love for the profession of his choice, was his love of doing good to his fellow-men.

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DR. A. A. ROTH.

DR. A. A. ROTH, of Frederick, Md., died June 24th, 1890, aged forty-three years. Dr. Roth received his classical education at Gettysburg College, and his medical degree from the Hahnemann Medical College, of Philadelphia, in 1870. He had been engaged in practice in Frederick for nineteen years, coming there at a time when he was the only homœopath for miles around. Dr. Roth was a fine classical scholar and close student. His untimely death is the direct result of his devotion to his profession. He leaves a widow and three sons.

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# GLEANINGS

## GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

**HYPODERMICS OF CAFFEINE IN A DYNAMIC STATES.**—Huchard praises the tonic and exciting effects of Caffeine in malignant cases of all zymotic affections, especially in debilitated and old people, and also in diabetes. In one word, it acts as a tonic in general, and especially so to the heart and to the urinary secretion. That it is a tonic to the muscular system is well known, for its use, like kola and coca, takes all sensation of fatigue away. In severe cases of pneumonia the insufficiency of the heart muscle constitutes a great complication, and, though the disease is in the lungs, the danger is in the heart. Caffeine strengthens the weak heart and increases diuresis. In diabetics it relieves the great danger arising from acetonæmia. Sem-mola, of Naples, agrees with Huchard regarding this strengthening effect of Caffeine. In collapse, such injections are far less painful than those of ether, and hardly ever become the cause of abscesses. He uses two formulas, a weaker and a stronger one. R. *Natrum benzoic.*, 3 grammes; Caffeine, 2 grammes; distilled water, 6 grammes. S. To be dissolved hot. Or R. *Salicylate of soda*, 3.10 grammes; Caffeine, 4 grammes; distilled water, 6 grammes; likewise to be dissolved while hot. The *natrum benzoic.* or *salicylate* are only accessory, to render the caffeine more soluble. Every syringeful contains 40 centigrammes of caffeine, and he makes about eight hypodermics daily.—*Bull. Méd.*, 50, 1890.

**VACCINATION FEVER.**—Dr. Peiper, of Greifswald, formulates the following conclusions in reference to the fever following vaccination: 1. At the usual age when vaccination is done, vaccinia is always accompanied by fever. 2. The commencement of the fever period is about the fourth or fifth day, the fever lasting from 2½ to 4 days, and is only of moderate intensity. During the fever dangerous manifestations do not occur. Its fall is a gradual one. 3. Particularly long-lasting fever is an indication of the presence of complications.—*Monatsh. für Prakt. Dermatol.*, Bd. 10, No. 12, 1890.

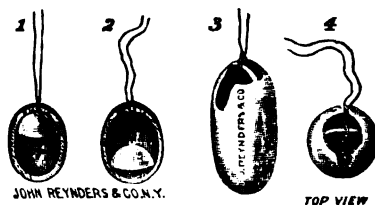
**CUTANEOUS ERUPTIONS OF LA GRIFFE.**—Dr. Barthelemy had observed two hundred and nineteen cases of grippe in the late epidemic, and found skin lesions frequent. 1. There were the simple coincidences—furuncles, anthrax, eczema. 2. Divers erythemas, which appeared with the existence and evolution of the grippe. There were rashes which preceded the disease, just as rashes precede the eruptive fevers. They were mostly morbilliform or scarlatiniform, the former being the more frequent. In one case there was a pityriasis-like eruption, and in another a vesicular outbreak. The scarlet-like eruption recalled descriptions of the dengue.—*Journ. of Cut. and Gen.-Ur. Dis.*, July, 1890.

**SALICYLATE OF SODA IN PLEURISY, WITH EFFUSION.**—Aufrecht and Tetz have treated a number of cases of pleurisy with effusion by the administration of salicylate of soda. The dose for adults was one gramme; for children, less, according to age. From four to six grammes were given daily. Its administration should be continued for a week or more after the inflammation has subsided. Since using this drug, they have in every case succeeded in producing absorption of the serous effusion. They also look upon the drug as a diagnostic agent, for when the fever does not yield to its influence after a few days, or the diuresis increases, they are assured that the effusion is a purulent one. In fresh cases recovery takes place within a few days. No injurious effects were noticed from the drug.—*Therap. Monatsh.*, July, 1890.

**TOPICAL ACTION OF DRUGS ON SECRETION.**—Dr. Emil Schütz, of Prague, gives the results of his studies on the action of certain drugs in arresting or dimin-

ishing or increasing the secretory activity of glands. According to the author, a large number of substances amongst the metallic salts, acetate of lead, nitrate of silver, sulphate of copper, among the acids, hydrochloric and sulphuric, and tannic applied to the skin or mucous membranes of frogs, have the effect of diminishing the secretion, this action lasting for hours or even days. The chlorides of potassium and barium act in a similar manner; almost all these substances possess the property of precipitating globuline, even in extreme dilution. The alkalies, the alkaline earths, the alkaline and neutral salts of the alkalies and numerous other substances such as glycerine, carbolic acid, mustard seed oil, phenol if applied at a proper degree of concentration, act in an opposite manner and increase the secretion. In both cases the effect is independent of the nervous and vascular systems, and depends upon the secreting elements only.—*Medical Press and Circular*, July 30, 1890.

**A NEW METHOD FOR OBTAINING SMALL QUANTITIES OF THE GASTRIC CONTENTS FOR DIAGNOSTIC PURPOSES.**—Dr. Max Einhorn, of New York, has devised a little apparatus, cuts of which are herewith appended, for the purpose of removing small quantities of the gastric contents for examination. This apparatus he has called the "stomach bucket." Those first constructed (see Figs. 1 and 2) had a valve-like lid which closed during withdrawal. This form was soon found impracticable. The apparatus which proved to be perfectly adapted for obtaining small quantities of the stomach contents consists of a small oval vessel (1½ ctm. long, ¾ ctm. wide, made of silver; see 3 and 4). On the top of the same there is a large opening with an arch over it. On this arch a silk thread is tied.



In order to obtain a sample of the stomach contents one proceeds in the following way: The patient is asked to open his mouth widely, and the little vessel is placed on the root of the tongue, almost in the pharynx. The patient is now told to swallow once. The vessel comes after a short time (one-half to one and one-half minutes) into the stomach. This point can be readily found by the length of the thread from the vessel to the mouth. It is advisable to make a knot on the thread marking 40 ctm. When this knot comes into the mouth we are sure that the vessel is in the stomach. The vessel is left *in situ* for five minutes when it is withdrawn. During withdrawal a resistance is usually felt at the introitus œsophagi. To overcome this difficulty, when the apparatus is at that narrow point, the patient should either expire deeply or swallow once. Dr. Einhorn has made numerous experiments with the stomach bucket, and assures his readers that it is a very useful instrument for the purpose for which it is designed.—*Medical Record*, July 19, 1890.

**THE DIAGNOSIS OF ACUTE PAINLESS DRY PLEURISY.**—Dr. R. Van Santvoord calls attention to this condition, illustrating his remarks by a report of three cases of the trouble. This he does, not because the affection is one not hitherto described, but because the diagnosis of the condition is an easy matter if the possibility of its existence is only borne in mind. We are too apt in actual practice to associate pain and dullness on percussion with the diagnosis of pleurisy. All three cases reported were characterized by entire absence of the usual subjective symptoms of pleurisy. Nor was there percussion dullness. All suffered, however, from cough more or less. In all the only physical sign was a subcrepitation not distinguishable in quality of sound from an intra-pulmonary râle. In fact, in two of the cases he regarded the sounds as intra-pulmonary at first. As they extended, however, their pleuritic character became manifest from their superficial character, the fact that extensive areas of a single lung were in each case involved, and the constant presence of the sounds, day after day, in the same place. Had they been bronchial râles they would have been bilateral, inconstant and affected by cough.

In remarking on the cases at length the author calls attention to the fact that Leaning, of New York, teaches that almost all râles are of pleuritic origin, a teaching with which he is not, however, in accord.—*Medical Record*, August 2, 1890.

**RESPIRATORY FUNCTION IN THE MOUNTAINS.**—Riva-Rocci, of Turin, has made numerous exact measurements with the pneumatometer to determine the effects of mountain air upon the respiratory functions. He draws the following conclusions: 1. During ascension there is an increase in the performance of the entire respiratory mechanism, an increase in the frequency and intensity of the whole respiratory act; hence expansion of the lungs, especially at the apices, is greater. This is an important observation, for it is at the apices that the lungs in the normal state show the least motion, thus favoring the development of a phthisical process. Simultaneously with the expiration there is an increase in the pressure of the air surrounding the lungs, which increases with each ascending step. 2. During ascension the chemical functions of the lungs also increase; hence there are more active organic metabolism and renewal of tissues. 3. During descension the reverse phenomena occur. 4. The periods of rest favor organic reintegration and assimilation, as is shown by improvement in the appetite and an easier digestion.

A sojourn in the mountains may therefore be indicated in persons who are threatened with phthisis. It is not necessary to send such persons to very high altitudes. The author prefers rather a country where the grounds offer a nearly continuous ascent or descent proportionate to the strength of the patient's heart. To get the full benefit of mountain air the patient should live like a mountaineer, and not expect to remain in quietude.—*Allgem. Med. Centr. Zeitung*, 57, 1890.

**REPEATED ATTACKS OF HÆMOPTYSIS AS AN EARLY SYMPTOM OF INTERSTITIAL NEPHRITIS.**—Houchard, Landouzy and Goucher have already called attention to epistaxis in adults as an early symptom of interstitial nephritis. Duclos has recently studied the frequent attacks of hæmoptysis appearing in persons of apparently good health, especially of the male sex, without any lesions of the heart or lungs, and whose complaints, if any, are of an arthritic nature, as migraine, eczema, hæmorrhoids, asthma, etc., are due to the same cause. Some of these cases suffered after some time from painful rheumatic manifestations; others had arterio-sclerosis, which gradually became general; while others again, without a trace of fibroid rheumatism or arterio-sclerosis, suffered from interstitial nephritis. Duclos mentions a case in which the pulmonary capillaries were attacked by the sclerotic process before the kidneys were even involved; hæmoptysis thus occurred with every coughing spell. Interstitial nephritis shortly set in, from which the patient succumbed after a few years.—*Rev. gen. de Clin. et de Ther.*, 21, 1890.

**ANGINA PECTORIS DURING THE COURSE OF INFECTIOUS DISEASES.**—Moore and Perl record that during the late stages of infectious diseases, especially septicæmia and diphtheria, symptoms of angina pectoris may set in, either from defective innervation of the heart, or from fatty degeneration of the heart-muscle in consequence of acute parenchymatous myocarditis, or from sudden increase in tension in the peripheral arteries. The treatment consists in alcoholic stimulants, in cardiac tonics (digitalis, nux vomica, strophanthus, strychnia), and finally, in the use of amyl nitrite and nitroglycerine.—*Centralblatt f. Med. Wiss.*, 25, 1890.

[That indefatigable student, Dr. S. A. Jones, of Ann Arbor, has called our attention in angina pectoris vaso-motoria to *lactroductus mactus* (*Homœopathic Therapeutics*, 3d edition, p. 31); in the septicæmic form *cuprum arsenicosum*, *crotalus* and *naja* deserve our study; while in the diphtheritic form we would think of *gelsemium*, *cactus*, *laurocerasus*, and *glonoin*. For fatty degeneration of the heart, *aurum* and *phosphorus* loom up as great aids.—S. L.]

**AN INFREQUENT CAUSE OF BALANITIS.**—Cordier calls attention to the fact that inflammation and even cauterization of the skin may arise from the simultaneous application of mercurial preparations externally, and the internal use of salts of iodine. Severe conjunctivitis may arise from the insufflation of calomel into the eye, when iodide of potassium is being given internally. A purulent balanitis may set in from applying calomel to the glans penis, and giving iodine preparations internally at the same time, especially when the patient has a long prepuce.—*Centralblatt f. Med. Wiss.*, 21, 1890.

**SPONTANEOUS RUPTURE OF THE HEART.**—Spontaneous rupture of the heart takes place only when the cardiac muscular fibres are diseased. Excessive increase of the blood pressure is never sufficient to rupture the sound cardiac walls. The structure of the cardiac muscle is frequently changed by neoplasms and by ulcerations originating in the endo- or pericardium and by cardiac abscesses; but its chief ætiological factor is a fibrous degeneration of the cardiac muscle leading to aneurismic dilatation and finally to rupture. More rarely one meets with fatty degeneration of the heart as a cause of this accident. Some admit syphilis as a possible ætiological factor. Of forty cases of sudden death, one, perhaps, is brought about by rupture of the heart. Spontaneous rupture of the heart is more frequently observed in the male sex, probably because of the greater frequency of atheromatous changes in them. For the same reason it is more frequently met with in the aged. The left ventricle is most frequently the seat of the accident; next to this comes the right ventricle. The auricles are very rarely involved. The point of predilection is the tip of the left ventricle. As to the size of the rupture, it may be so small as to barely admit the point of a sound, or, again, it may be so large as to extend from the apex of the ventricle to its base. According to time, the cases of rupture of the heart may be divided into two groups: those in which the rupture sets in suddenly and death follows immediately; and those in which the blood gradually finds its ways through the cardiac muscle, and death is preceded by characteristic manifestations, as intense præcordial anguish, pain in the left side of the thorax, sensation of fainting. In rare cases the rupture may be incomplete; thus, life may be prolonged for quite a while after its occurrence.—*Centralbl. f. Klin. Med.*, 16, 1890.

**A SIMPLE METHOD FOR THE DETECTION OF GLYCOSURIA.**—Dr. Becker, of Cairo, reports that the paper manufactured for visiting-cards, contains a large quantity of potash in order to make it fuller and heavier. If one draws a line on a visiting-card with a concentrated solution of sulphate of copper, the latter crystallizes on the surface when drying. Now, place a drop of urine on the line and dry it over a flame, when, if sugar should be present, the brown color from the saccharine reaction is seen. The more sugar contained in the sample of urine, the darker will the line be made.—*Wien. Med. Presse*, 20, 1890.

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## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

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**TREATMENT OF STERILITY FROM ENDOCERVICITIS WITH IODINE IN THE NASCENT STATE.**—In these cases, Brouardel finds the cervix uteri of a bluish color, and the os tincæ closed by a tough mucous plug. It is his custom in treating them in the course of seven weeks to make fifteen glycerine applications, and eight of iodine, according to Cheron's method. The os is then clear, and the cervix assumes the normal appearance. Pregnancy can then take place. The same method of treatment is indicated in catarrhal endometritis.

The preparation necessary to liberate the iodine is a solution of iodide of potassium in five parts of water. With this the cervical canal is thoroughly cleansed, after which a solution of citric acid of the same strength is applied on a tampon. The mixture of the two solutions sets the iodine free. These applications should be made every third or fourth day.—*Deutsche Med. Zeitung*, 51, 1890.

**EXFOLIATION OF THE FEMALE BLADDER.**—An exceedingly interesting and very rare case of so-called exfoliation of the vesical mucous membrane is described by Dr. Haultain, the subject being a woman aged twenty-seven years. The patient suffered from retention of urine, due mainly to the presence of a mass within the bladder, but protruding at the urethra, its measurements being fourteen by seven and one-half inches at its broadest diameters, and in thickness, a fifth to an eighth of an inch. Microscopical examination showed the substance to possess a truly membranous structure, three layers, a crystalline granular, transverse muscular, and longitudinal muscular tissue being recognizable. At one point, a portion about one and a

half inches square, exhibited a smooth white glistening aspect, and here there were added an old and a new connective-tissue layer. On the evidence afforded by the careful examination by the membrane, Dr. Haultain maintains that it consisted of the entire thickness of the bladder-wall in a state of hyaline necrosis, the white part observed in his case consisting of attached peritoneal covering. He insists, therefore, upon the inapplicability of the term, "exfoliation of the mucous membrane" applied to such cases, under which name similar examples to his own have been reported by various writers. The causation of the disease he attributes to circulatory disturbance due to retention of urine or labor, these being, one or the other, the two concomitants of all the cases hitherto recorded.—*London Medical Recorder*, July 20, 1890.

**ARTIFICIAL PROLAPSE OF THE UTERUS: ITS DANGERS.**—Certain foreign gynecological authorities look upon artificial prolapse of the uterus for diagnostic and therapeutic purposes as a perfectly safe and oft-indicated procedure, and furthermore one that should be utilized frequently. From this opinion Dr. H. C. Coe dissents, and thinks that not only has the procedure been followed by bad symptoms, but for diagnostic purposes should be used seldom, if ever.

As usually performed, the anterior lip of the cervix is seized with the volsella, and the uterus is drawn downward while the examiner introduces the finger into either the rectum or vagina—in the former case with the view of mapping out the fundus of the uterus, the adnexa and morbid growths within the pelvis, in the latter usually for the purpose of exploring the uterine cavity after previous dilatation of the cervical canal. Examination per rectum with the uterus thus dislocated is commended as a means of diagnosing displacements of the uterus and adnexa, and determining the relation of intrapelvic and abdominal tumors to the uterus. The author thinks that with thorough understanding of the performance of bimanual examination, artificial prolapse of the uterus becomes unnecessary, for experience has taught that it is in the cases of doubtful tumors, in which downward traction upon the uterus has been followed by serious results.

The manipulation can, however, be practiced with less danger in cases in which the object is to make digital examination of the uterine cavity easy. Here the trouble is supposed to be entirely intrauterine, the uterus is freely movable and the patient etherized. Even here the better way to bring the uterus down is by pressure from above rather than by traction with volsella from below.

As an aid in gynecological operations the manipulation is by no means free from danger. It may by overstretching the already relaxed supports of a heavy uterus by prolonged traction, lessen their tone. It may tear peri-uterine adhesions, thus starting up fresh inflammations. Or, injurious traction upon a pyo-salpinx or abscess of the ovary may cause rupture of the same with escape of pus into the peritoneal cavity; or setting up a fresh peri-ophoritis or peri-salpingitis greatly aggravate the existing trouble.

Dr. Coe reports five cases in which he has seen peri uterine inflammation set up by undue traction during operation. In the operation of trachelorrhaphy he thinks traction on the uterus unnecessary, as a skillful gynecologist can readily repair the tear with the cervix in its normal position. In closing he emphasizes the importance of distinguishing between fixation of the uterus with the double tenaculum and the downward traction with volsella, the latter of which he prophesies will gradually sink into "innocuous desuetude."—*Medical Record*, August 9, 1890.

**REMARKABLE CASE OF RUPTURE OF THE UTERUS.**—A patient was shown recently before the French Academy of Medicine, with a history that is probably unique, both in respect of the lesion and her survival. In the course of a labor obstructed by pelvic deformity, the uterus was ruptured, but at first laparotomy was refused. Twenty-four hours later version was resorted to, but though the trunk was readily brought down, the head remained fixed and had to be detached. Laparotomy was then consented to, and on opening the abdomen the surgeon found the head lying free in the cavity of the peritoneum; but it was only after a tedious exploration that he was enabled to identify the uterus, which was completely separated from its vaginal attachments, and was located in close proximity to the under surface of the liver. Only the Fallopian tubes and a few shreds of the broad ligaments remained. Though by no means sanguine as to the patient's chances of recovery, the practitioner put the uterus back into its proper position, and stitched it there as well as he could. Being in the country he naively tells us that no antiseptic precautions were possible. He did the best he could under the circumstances, and—

most remarkable of all—the patient made a prompt and uninterrupted recovery. It would be unkind to criticize a line of treatment which was sanctified by such a brilliant and unhoped for result, but one would imagine that the removal of the uterus would have afforded the best chance for the patient.—*Medical Press and Circular*, July 2, 1890.

**HYPODERMIC INJECTIONS OF CAFFEINE IN POST-PARTUM HÆMORRHAGES.**—Misrachi highly recommends hypodermic injections of caffeine in post-partum hæmorrhage, especially in such cases as require immediate aid, and after great loss of blood has taken place. It is especially useful in country practice, when perhaps, the physician has just come from a case of infectious disease, and there is not time for auto-disinfection preparatory to introducing the hand into the uterus. Caffeine acts more quickly than ergotine, and is more stimulating than ether. The formula of the fluid for hypodermic use is as follows: Benzoate of soda, 3 grammes; caffeine, 2.0–2.5 grammes; aqua destillata, 6.0 grammes or *quantum sufficit* for 10 cctm. Every cctm. contains 0.25 grammes of caffeine. The solution is administered warm, from six to ten injections in the course of the day. Misrachi has witnessed such brilliant results from it that he now carries this solution regularly in his obstetrical case. Tablets of benzoate of soda and caffeine to be dissolved in boiling water when needed, will do instead of the standard solution.—*Arch d'Obstet. et de Gyn.*

**INDUCED ELECTRICITY IN UTERINE HÆMORRHAGES.**—Dr. Eugen Boér remarks in a Hungarian journal that though iodoform gauze plugs carefully applied will usually arrest the flow in menorrhagia, still cases occur in which this plan will not succeed, because probably the hæmorrhage is due to atony of the uterus. In one case of this kind, that of a girl of eighteen, having tried all the usual internal and local remedies, and the patient having become unconscious from the loss of blood, he determined to try the faradic current, which arrested the hæmorrhage in ten minutes; and again, when three days later, there was a slight return, the same method was resorted to with success. The effect also was of a permanent character, for though the faradization had to be resorted to at the next period, the subsequent one was normal. A similar treatment proved equally successful in the case of a multipara with profuse and intractable menorrhagia. At first, Dr. Boér applies the negative pole directly to the cervix, and after the arrest of the hæmorrhage to the perineum, the positive pole being applied with some little pressure to the abdomen over the fundus uteri.—*The Lancet*, July 19, 1890.

**SECRETION OF BLOOD INSTEAD OF MILK.**—Dr. Habergritz, of Witebsk, Russia, reports in the *Allgem. Med. Zeitung* a case of the secretion of blood in the breasts. The patient was a young married woman, who, when she had been pregnant with her first child about six months, consulted Dr. Habergritz as to whether the fetus was alive. He noticed some blood stains on her linen in the neighborhood of the breasts, and on examination, found that drops of pure blood could be expressed. The patient said that the bleeding had begun when she was five months pregnant, and she did not know that it was an unusual occurrence, and therefore had not mentioned it. During the rest of the pregnancy the phenomena continued, and the patient suffered besides from two or three attacks of epistaxis. Two days before labor came on the bleeding ceased, but it reappeared in increased amount the day after. The patient was very anxious to nurse the child, but as it drew nothing but blood, this had to be put a stop to. On the seventh day the color of the secretion began to change, and by the eighth it had all the ordinary appearance of colostrum. The child was then allowed to take the breast, and nothing further abnormal was observed. It should be mentioned that the woman was perfectly healthy; that there were no traces of gonit, hæmorrhoids, cancer, or of the hæmorrhagic diathesis.—*The Lancet*, July 19, 1890.

**CYSTIC DEGENERATION OF THE KIDNEYS IN A DROPSICAL FÆTUS.**—A multipara had only felt the movements of the fetus up to the eighth month of her pregnancy. When Gueniot came to deliver her, he found that while the pelvis was of normal dimensions, and the head of the child engaged, and severe contractions of the uterus took place, no progress was made. While disengaging the arms, the child breathed its last. All the visible parts were highly œdematous. On introducing the hand into the uterus the obstacle to delivery was detected in a highly distended abdomen. A puncture gave exit to sixty grammes of ascitic fluid. Evisceration followed. The

liver was large, and the kidneys full of small cysts of a grayish tissue.—*Semaine Med.*, 18, 1890.

**THE CURE OF UTERINE FIBROIDS BY THE LIGATION OF THE UTERINE ARTERIES.**—Rydygier proposes to cure fibroid tumors by cutting off their nutrition by ligation of the chief arteries of the uterus. After laparotomy he carries double ligatures around the anterior spermatic artery (in the lateral ligament), the uterine artery (at the edge of the uterus), and the anastomosis running in the round ligamentum. It is self-evident, that it is necessary to do this operation on both sides in order to make it effectual. All three arteries can be readily made out. This procedure is far less dangerous than castration, and is moreover more effectual, and does not interfere with the sexual life of the woman. Rydygier has treated thus an intramural fibroid of the size of two fists, and reduced it to half its former size in less than four months.—*Berliner Klin. Wochenschr.*, 15, 1890.

**AGALACTIA.**—In several cases Mensinger has succeed in producing a copious flow of milk in women, who during previous lyings-in had been unable to nurse their infants. He begins his treatment during pregnancy. He has the mammae sponged several times a day with cold water; after which he uses massage centrifugally from the nipple all around. After a few sittings the veins become fuller, and the breasts more tense. Mensinger has never noticed that this manipulation of the breasts excited uterine contractions during the pregnancy.—*Berliner Klin. Wochenschr.*, 15, 1890.

**CARDIAC TROUBLES DURING THE MENOPAUSE.**—In women during the menopause, Dr. Kisch, of Marienbad, has frequently observed paroxysmal tachycardia with sensation of anguish, hot flashes, vertigo, pulse of from 130 to 150 to the minute, and great irritability; but these symptoms usually passed away sooner or later, without any bad consequences. They are the result of reflex irritation excited by a hyperplasia of the ovaries. Of greater importance is cardiac weakness during the climaxis, mostly observed in delicate women, or in women greatly weakened by frequent hæmorrhages. The symptoms in these cases are as follows: Cardiac asthma, angina pectoris, great dyspnoea and stasis, as shown by the oedema and the albuminuria. A physical examination is necessary in order to determine the cause of the hæmorrhages. A third group depends upon the troubles emanating from the fatty heart. Any exertion may then cause dyspnoea and palpitations; but it will hardly ever be the cause of a full asthmatic paroxysm, only exceptionally in women who in early life showed a tendency to obesity.—*Centralbl. f. Med. Wiss.*, 24, 1890.

**A NEW METHOD OF INDUCING NATURAL LABOR.**—Women with narrow pelves can only pass through a natural labor when the fetus is in a less advanced stage of development. Prochawnick and Swiacky tried successfully to produce such a state at the normal end of pregnancy by placing the mothers during the last two months of their pregnancy on a diet similar to that prescribed for diabetic patients. Breakfast, a small cup of coffee, with 25 grammes *zweiback* (twice-toasted bread); dinner, all sorts of meat, fish, with hardly any gravy, eggs, some green vegetables, salad, cheese; supper, the same, with 40–50 grammes bread and some butter; fluids daily, 300–400 ctm. red or Moselle wine. The articles not allowed are water, soups, potatoes, pastry, sugar and beer. Of three cases, treated by Prochawnick, one had a conjugate diameter of 10.8 ctm. She was twice delivered by version and perforation, and three times by premature delivery, and all children died. In the second, conjugate diameter was 10.4 ctm.; in the third, 10. ctm. Artificial premature delivery had been performed in all of these, but all the babies were lost. All three women were put upon the prescribed diet, and their deliveries were easy and required no artificial aid. The babes looked emaciated, were of light weight (2350, 2400, 2250 grammes), but of normal length (50½, 51, 52 ctm.). The bones were fully formed and hard, the skull normal, with the exception that its bones could be shoved one over the other; the amniotic fluid was scanty. All the babies did well and increased rapidly in weight and strength. After their natural deliveries the mothers were put upon more nourishing diet, especially carbohydrates and milk; two of them were able to nurse their babes. Swiacky tried the same diet on four women with narrow pelves (conjug. were 9½ down to 6½ ctm.) and reports the same successful issue, and recommends its trial in similar cases.—*Deut. Med. Wochenschr.*, 29, 1890.

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**A NEW THEORY ON LABYRINTHINE VERTIGO.**—The influence of labyrinthine impressions on the maintenance of equilibrium of the body is now generally believed to have been demonstrated by the experiments of Flourens on the semi-circular canals of pigeons, and to have been confirmed by the pathological researches of Menière. Indeed, all text-books contain the doctrine that destruction of these canals produces definite and special disturbances of equilibrium, which render any proper co-ordination of locomotion impossible. Many years ago, however, Schiff protested against this theory, on the ground that section of the trunk of the auditory nerve did not cause any disturbance of equilibrium; while, more recently, Böttcher drew attention to the circumstance that in pigeons, on which these experiments have generally been made, the canals cannot, for anatomical reasons, be destroyed without injuring at the same time the cerebellum, thus giving a fruitful source of errors. The most serious objections to this theory have, however, now been raised by Professor Steiner, of Cologne, who has experimented on sharks caught in the Bay of Naples, in which class of fish the semi-circular canals are particularly developed, and which are, therefore, most suitable for such experiments. The skeletons of sharks being cartilaginous, laying bare the semi-circular canals is very easy; they are superficially situated beneath the skin, and separated from the brain by a considerable mass of cartilage, so that injury to the brain can be easily avoided. Steiner has found that when the membranous canals of sharks are laid bare and excised, and the wound is then closed and the fish put back into the water, not the slightest disturbance of locomotion ever follows. On the contrary, if after laying bare the labyrinth, the trunk of the auditory nerve, or the ossicles surrounding the same, are pulled and stretched, then there is invariably a disturbance produced in the form of rotatory or circular compulsory movements. If the latter operation be performed unilaterally, the direction which movements take may in each case be predicted. Such traction of the nerve trunk need only be slight in order to produce motor disturbance. The same result follows if no section of the canals be made, but one of them is pulled and stretched so that the ossicles change their position. These experiments show that in sharks the semi-circular canals, have by themselves, nothing to do with equilibration, and that when motor disturbances follow, they are owing to traction and irritation of the origin of the auditory nerve in the medulla oblongata, and are the same as are produced by other similar irritation of that portion of the medulla. Steiner has shown that the same results, as in sharks, are obtained in frogs and lizards. In the higher vertebrates the anatomical relations of the parts concerned are so complicated, that it has hitherto been found impossible to avoid sources of error in experimentation. Ewald's recent experiments on pigeons likewise seem to lead to similar conclusions. In one experiment he removed the six ampullæ from a pigeon, which survived the operation, and being very tame, followed him afterward in a straight line through several rooms. The same animal, however, when left to itself, was apt to walk in a circle, sometimes to the right and sometimes to the left side. Why should the animal walk straight when following its master, and in a circle when left to itself? Steiner explains this by assuming that compulsory movements are produced by the loss of cutaneous and muscular impressions consequent upon the operation, and this loss may be neutralized in the higher animals by the influence of the eye and the intellect upon movements. The pigeon, therefore, overcomes the tendency to compulsory movements by fixing its attention upon the movements of its master. The vertigo of Menière's disease would, therefore, appear to have its source rather in lesions which affect the brain or its membranes, or cause alteration of pressure. That the semi-circular canals have nothing to do with it is also shown by a case recorded by Politzer, in which there was congenital absence of all semi-circular canals, yet no disturbances of equilibration had taken place during life; and another one of Lucas, in which the canals were found filled with blood clots, and where there had been



before death no corresponding symptoms showing that this condition had interfered with equilibration.—*The British Medical Journal*.

**EXCISION OF THE OPTIC NERVE.**—We recently commented on a proposal that had been made by M. Abadie to prevent sympathetic ophthalmitis by sterilizing the injured eye, by injecting into it a few drops of a solution of corrosive sublimate. The theory on which this proposal rests is, of course, that sympathetic inflammation is a septic process, due to the passage of microbes along the lymph spaces of the optic nerves and chiasma. While accepting the theory, we demurred to the practice, on the ground that it is not possible effectively to sterilize the contents of an eyeball without using an agent which would destroy the vitality of the tissues, and that it was, therefore, better either to remove the globe altogether, or to remove the contents of the sclerotic and sterilize its cavity.

A lengthy paper in the *Klinische Monatsblätter* for June by Dr. Otto Scheffels urges the claims of another substitute for enucleation, namely, resection of the optic nerve. This is in no sense an outcome of the septic theory of causation, as it is merely a further development of simple neurotomy, which was originally instituted when it was believed that the ciliary nerves formed the communicating medium for the transmission of sympathetic affections. It is now maintained that this practice is in perfect harmony with the septic theory, indeed, the author to whom we have just referred, considers that the success of this operation in preventing sympathetic inflammation, should it be confirmed by a larger number of cases, is itself to be considered as a proof of the correctness of the theory. The reservation is an important one, as it is impossible to form any notion as to what number of cases would be necessary to prove that it affords absolute immunity. But even were this proved, we fail to see what support would be given to the septic theory, for the ciliary nerves are necessarily divided at the same time, and, as it is at least as likely that lymph channels should be restored as nerves, the success of the operation would be quite as much in favor of the ciliary nerve theory as of the bacterial.

The author considers that if  $7\frac{1}{2}$  millimetres of the optic nerve with its sheaths are excised, it is impossible that the lymph channels should be restored, and that the gap will form a gulf which the microbes cannot pass. Both these assumptions are, it seems to us, gratuitous. We are not aware of any experiments or observations bearing on the question of divided lymph channels, and as Dr. Scheffels quotes none we presume he is in the same condition, but as no profound change takes place, as far as can be seen, in the nutrition of the eye, it is not unreasonable to suppose that the lymphatic circulation is carried on somehow. Because we know little about the habit of these microbes, every one thinks himself at liberty to attribute to them virtues and impotences that best accord with his own views, but we are not acquainted with any evidence, apart from that afforded by the few recorded cases of neurectomy, and this is of the weakest description, that microbes cannot extend through  $7\frac{1}{2}$  millimetres of cellular tissue, even though the main lymph channels have been excised.

If the bacterial theory can be proved by other means, and for our part we consider that the evidences in support of it are exceedingly strong, then a large number of neurectomies would go so far to prove that excision of a portion of the optic nerve does form a barrier to the progress of microbes, but, considering the risk run, such a wholesale clinical experiment would in our opinion be wholly unjustifiable, at any rate until the probability of success has been demonstrated upon animals.

The operation, however, has a definite field of usefulness. When an eye is blind and painful and is causing sympathetic irritation of the other eye, while from the nature of the case there is no fear of sympathetic ophthalmitis, neurectomy may be useful as a substitute for enucleation, and as far as known is always successful. The operation itself presents no insuperable difficulties, although we think the author makes too light of the trouble arising at the time of the operation from hæmorrhage into Tenon's capsule. On two occasions we have seen this entirely prevent reduction of the globe, so that enucleation had to be performed. The internal rectus is sutured and divided, the nerve felt for and divided as far back as possible, the distal end is then seized, its sclerotic attachment brought into the wound, where it is cut off as close to the globe as possible. Finally the divided muscle is united by means of sutures left in it for the purpose.

Simple neurotomy, although it has been quite successful in many such cases, has in some proved to be of only temporary benefit, owing to the reunion of the divided nerves. It is, however, a comparatively simple operation, and might in many

cases be tried first, neurectomy being reserved for recurrent symptoms.—*The British Medical Journal*, July 19, 1890.

**EAR REFLEXES.**—Downie describes various reflexes having their origin in the ear which are familiar to otologists, but, perhaps, not as well known by general practitioners. Cough, this writer says, may be excited by introducing unwarmed specula into the meatus, and may also be produced by inspissated cerumen, especially if the mass is loose and changes its position during the movements of the lower jaw. This cough is often falsely called "stomach cough." Foreign bodies in the ear may produce similar phenomena. The author reports an example in which a phthisis-like cough with pulmonary symptoms disappeared after removing a plug of cerumen. Irritation of the external canal may cause gastric reflexes, such as vomiting. Aural polypi, as well as cerumen plugs, may excite irregular cardiac action, which rapidly disappears after removing the local trouble. Epileptiform convulsions may be due to the same causes, in proof of which the author cites a series of cases observed by himself.—*Archives of Gynecology and Pædiatry*, July, 1890.

**ANÆSTHESIA IN SMALL SURGICAL OPERATIONS, WITH HYPNOTISM AND SUGGESTION.**—An interesting translation by Dr. Max Toeplitz, of New York, of a paper by Dr. Ad. Barth, of Berlin, cites examples of the use of cocaine apart from its anæsthetic effect for chronic swelling of mucous membranes. He says that in the beginning the patient is relieved by its use, but finally sensations of general uneasiness, frontal pressure, tendency to sneezing, want of sleep, are excited by its continual application. In such cases repeated swabbings of the nasal mucous membrane with a twenty per cent. solution of cocaine neither markedly decreased the swelling nor produced anæsthesia. The remedy had a better effect after an intermission of a few days without application. In view of this and like experiences cocaine cannot be recommended for continuous local treatment in chronic inflammation of mucous membrane, as little as for internal medication.

Dr. Barth has lately (1888) tried hypnosis for the purpose of anæsthesia, which has now met with well-deserved approval among German scientists. He briefly mentions some characteristic examples as they are met in practice. A servant girl, aged eighteen, is, except for an affection of the nose, otherwise healthy. The tip of the nose is reddened and thickened, the epidermis is rough and thrown off in large scales. The nasal mucous membrane presents when examined at different times various swellings. After thirteen days' treatment the epidermis ceased to scale and had become smooth. Redness and swelling were lessened, but had not disappeared and seemed to emanate from a whitish swelling the size of the head of a pin upon the centre of the nasal dorsum, having the appearance of a small transparent atheroma. When punctured with the scalpel blood escaped. Six weeks later the swelling was excised in hypnosis after cocaine cataphoresis. After cataphoresis had acted for ten minutes, hypnosis was brought about by fixing the eyes upon a small, unpolished metal button and by suggestion. The procedure appeared at first to be ridiculous to the patient, who was inattentive, but finally she fell fast asleep in less than five minutes, so as to be unable in spite of repeated loud requests to open her eyes. The head of the sitting patient was then fixed by suggestion in the position most convenient for operation, which was retained like a wooden figure until the operation was finished. Washing of the nose with sublimate, oval excision of a piece of the skin, which contained the white portion, and adjusting of subcutaneous fatty tissue with pointed scissors. No cyst or similar structures were found. During the operation comparatively profuse capillary bleeding. The patient did not move during the whole time. Insertion of three sutures. At the first the eyes were opened and the fingers slightly moved. The eyes were therefore closed with the following suggestion: "Being asleep and insensible, how can you open your eyes?" After the sutures had been applied while she was quietly sleeping, she was requested to awaken. She looked around with the peculiar dull glance of a person aroused from natural sleep. When asked whether she had felt anything or knew what had been done with her, at first no reply was made. But when further questioned whether she knew that I had incised and sewn her nose, she asserted that she had felt everything. Three days later I asserted that she did not sleep, but had been quietly sitting, because she thought she was compelled. After the small wound had healed, *per primam*, under iodoform collodium, the sutures were removed under hypnosis. In spite of the request to resist falling asleep, hypnosis took place after less than four minutes, so

as to keep the eyes closed in spite of loud requests. Immediately after the removal of the third suture the lids rose spontaneously. When asked whether she had slept this time she replied, "No." "Why did you not open your eyes?" "I could not do it." The face, moreover, was during the different procedures not moved in the least. This would have been surely the case in unpleasant or even painful sensations. The nose has now been pale for several months, but does not swell any more. This is in a measure a school case, which demonstrates that even moderate hypnosis greatly facilitates an operation for the patient as well as for the surgeon. The case just related was hypnotized because of the patient's fear and also of the long duration of the operation.

An entirely different cause for hypnosis was offered by the following case: A female patient, *æt.* twenty-five, was troubled for a long time by mucous discharge, and principally by a persistent sensation of tickling in the throat. The faucial tonsils were found to be considerably enlarged, not toward the middle line, but as flat hypertrophies; besides large granulations upon the posterior pharyngeal wall. Galvano-caustic treatment was agreed upon. The patient placed herself in the proper position, but just in the moment when I intended to introduce the instruments into her mouth they were pushed away with a jerk. Although the patient felt very much ashamed on account of her lack of self-control, further trials were of no avail. In order to attain my end, I proposed hypnosis. As the patient had been formerly present at one of Hanson's performances, I omitted further suggestions, and simply asked her to fix her eyes on an unpolished metal button, while I was busy at my writing desk. After less than five minutes she slept soundly, did not answer when called, and did not open her eyes when requested. At the command to open the mouth, I used slight pressure downward, stroked over the region of the maxillary joints, and suggested that the mouth could not be closed. I then introduced a wide tongue spatula, and canterized. At each sizzling of the cantery the head was slightly moved backward, and the hands rose. But when I assured her, "Since you are sleeping and not feeling anything, you should sit still," the hypnosis remained undisturbed. The hand was at times slightly pressed against the forehead and eyes in order to attain a better effect. I could thus remove the swelling in several sittings, and greatly diminish the symptoms. The patient did not always readily decide on hypnosis, because this state of weakness was apparently an unpleasant sensation. She could, moreover, afterwards state most of what had occurred and was said during the hypnosis.

In the other two cases we had to deal with hysterical persons. A piano-teacher, *æt.* twenty-six, suffered from marked hysteria, which was influenced by domestic affairs and strenuous activity. Apart from other symptoms, she was greatly troubled by nasal obstruction, to which headaches were attributed. The mucous membrane of the turbinated bodies, especially that of the middle, was extremely hypertrophied, so as to fill almost entirely the nasal meatuses. The left middle turbinated body was soft and flabby, resembling a polypus. After brushing the nasal mucous membrane with a solution of cocaine, I made her fix her eyes, and suggested. The effect was readily brought about; not, however, as a sleep-like condition, but after the patient had been sitting quietly, like the stage of excitation in beginning narcosis; she threw the head, arms and upper part of the body about, and exclaimed, "I want to go home, I do not need to stand everything," etc., all in the tone of an ugly child, but at the same time looking around drowsily. I gently pressed the eyes together, and talked energetically to her: "You have no will, nor can you exert your will, because you are asleep." She became quiet immediately, but some convulsions appeared in the arms. I deprecated even that, saying that this does not occur in this sleep. The head fell as if in sound sleep toward one side, and I did not succeed in steadying it by suggestion, so it had to be held. Either lower turbinated body was energetically canterized, whereby, at the most, the respiration was shortly retarded or more energetically performed, while no other movement was noticeable. The patient was then asked to awaken. She was breathed upon and the face sprinkled with cold water, but without success. But I succeeded immediately by the slightest pressure upon the hysterical pressure-point in the centre of the vertex. The patient opened her eyes, and simultaneously seizing her head with both hands, exclaimed: "A heavy load seemed to press upon my head." She had not the slightest idea of what had happened to her during the hypnosis.

The second hysterical case was a widow, *æt.* forty-four, sent to me by Dr. DuBois Raymond, because it was supposed that the lachrymation, lasting for months, was caused from the nose. There existed, principally on the side corresponding to the

affected (left) eye, large soft hypertrophies of the lower and middle turbinated bodies. At the first sitting I removed, under cocaine anæsthesia, the anterior end of the lower turbinated body with the galvano-caustic snare. At the moment when I pulled out a piece of the hypertrophic tissue of the size of a small cherry, the patient fainted, fell to one side and was seized with convulsions, although, as she afterwards stated, she had not experienced the slightest pain. By slapping the face vigorously with a cloth dipped in cold water, she soon recovered her senses, and was able to go home. There she was seized on the same day with two attacks of convulsions, from which she formerly never suffered, although she was subject to fainting spells. At the next sitting I began the hypnosis immediately after cocainization, which soon took place, at the beginning with slight movements of the throat and arms, which soon gave way, upon suggestion, to quiet, sound sleep. There existed complete anæsthesia, so as to be able to pierce the skin of the hands and face with a needle without the slightest reaction. After cauterization of the hypertrophic mucous membrane, it was especially suggested that no convulsions would follow. In consequence of a simple command, the patient awoke and was able to walk home. The convulsions did not occur. At the third sitting the convulsions began to appear during cocainization, but they were cut short by immediate hypnosis. At the fourth and last meeting, therefore, her eyes were pressed together as soon as she was seated in the chair, and she was commanded: "You must sleep." In a few seconds profound hypnosis took place. The nasal mucous membrane was apparently profoundly anæsthetized when I commenced the application of cocaine. I will add that also in this patient the head could be easily steadied by suggestion.

Dr. Barth says that such experience is quite encouraging for further experiments, although hypnosis has also its drawbacks, among which he emphasizes especially, that we do not, or with difficulty only, succeed in establishing hypnosis in every case. On the other hand, hypnotized persons may retain so much psychical self-control as to resist an operative procedure. He continues: "I do not, of course, intend to enter in detail into the nature of hypnotism. I rather recommend to those who seek information on the subject, Bernheim's book, *De la Suggestion et des ses Applications à la Thérapeutique*, second edition, Paris, 1888 (translated into English by Dr. Herter, published by Putnam's Sons, New York), which has been frequently recommended by others.

"I produce the hypnosis according to Liébault-Bernheim, by drawing the attention to the idea of sleep, and I tried to prevent a diversion of the mind by having the eyes fixed upon an object. While I thus laid the main stress upon the suggestion, it impressed me to have a better effect, if the person to be hypnotized was not directly addressed, but a third and entirely unconcerned person. I have never tried to keep up hypnosis for more than ten minutes, and I believe that I succeed in hypnotizing more than half of the people just as they come under treatment. The percentage will surely be increased with further practice. According to Liébault, less than 3 per cent. of people remain uninfluenced by suggestion. We can regulate, to a certain degree, the character and course of hypnosis by a suggestion, which mostly consists of simple, but impressive words, at times of energetic command. The patient's fear of an operation did not, as a rule, appear to me as being an obstacle to the production of hypnosis, as is asserted by Masoin, and also by Bernheim; for I have hypnotized several extremely timid persons. On the other hand, there are surely patients whose mind is so much enwrapped by fear as to render the hypnotizing influence without effect. Since we never know beforehand how deep the hypnosis will become, and principally whether we will succeed in producing thereby anæsthesia, I have always simultaneously used local anæsthesia in operations, leaving to the hypnosis only the removal of the undesirable action of the psyche. On inquiries, it was invariably stated that operations are not so unpleasant in hypnosis as with clear consciousness. In complete anæsthesia with subsequent amnesia, this is a matter, of course. Still better results in this direction will be obtained by occupying the mind of the hypnotized person during the operation in a quiet but pleasant way. Whether a physician ought to hypnotize patients only in the presence of others or not, this coincides, according to my opinion, with the question, whether he is at all permitted to receive patients alone? I consider an argument on this matter as superfluous. I have never seen, as well as Liébault-Bernheim, Forel, Sperling, Welbœuf, injurious effects from hypnosis, and I believe that their appearance is not the fault of hypnotism, but that of the hypnotizer. Just because very much depends upon experience and practice, and because in those cases, in which injurious effects easily remain behind, considerable medical knowl-

edge is required, I deem it necessary that the medical profession only practice hypnotism. I emphasize the importance of the fact that all hypnotized persons should, before awakening, be addressed by a suggestion pointing to complete good health. How careful we have to be in our expression, is demonstrated by the following example: I suggested to an hysterical person before awakened from hypnosis, 'When you now awaken, you will not be seized with convulsions, etc.; wake up.' Hardly a minute after being awake, a convulsive attack set in in the waiting-room. When called, I brought, in a very short time, the patient into quiet, sound sleep by placing the hand upon the eyes and forehead, with corresponding suggestion. The suggestion was as follows: 'You have not formerly paid sufficient attention to your condition; now, behold! You will never have convulsions, neither to-day, nor later, etc. Open your eyes, now! Wake up!' whereupon the patient regained consciousness and quietly walked home.

"For the objects which I have in view, I concur entirely with Forel, as you may infer from my remarks, that the application of the entirely safe suggestion (I do not mention the dangers incident to its unskilful, criminal or improper use) will, no doubt, gradually occupy the position it deserves in therapeutics; its indications should be rendered more precise, and freed from exaggerations, and the correct manipulation should be learned. I, therefore, advocate experiments with hypnosis in proper cases, being convinced that, also, in our specialty it will secure for itself a permanent place in the diagnostic and therapeutic management of hysterical deafness, subjective noises, hyperæsthesia and like conditions, as well as in small operations."—*Archives of Otolaryngology*, April-July, 1890.

## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

**ECCHYMOSIS OVER THE MASTOID AS A SYMPTOM OF CRANIAL FRACTURE.**—In his admirable lectures on "Some Points Relating to Injuries of the Head," Dr. Battle calls attention to ecchymosis in the region of the mastoid process after injuries as a symptom of fracture of the posterior fossa of the skull. Observations on this subject have led him to the following conclusions respecting mastoid ecchymosis: "That it appears in the first place in front of the apex of the mastoid process; that it often spreads upwards over the mastoid in a line, slightly curved, and with the convexity backwards, its direction being approximately that of the outline of the external ear, from which it is distant half to three-quarters of an inch. At the end of three or four days after its appearance, it diffuses itself forwards and backwards, chiefly, however, in the latter direction, being most marked in the original line, and then gradually disappears; that it usually shows from the third to the fourth day after the injury, but its appearance may be delayed until the twelfth to the fourteenth day. If the injury which is in the occipital region is to the right of the median line, the ecchymosis will appear on that side over the anterior part of the apex of the mastoid process; that it may be accompanied by oedema and tenderness over the process; that the duration of time which elapses between the receipt of the injury and the appearance of the ecchymosis may be taken to some extent, as an indication of the distance of the seat of fracture from the process, the blood being compelled to travel by a certain anatomical route in order to reach the surface; that unless search be made for the extravasation it is very apt to be overlooked, as the ear conceals it, especially if the ear be large or the head of the patient has not been shaved. Should the fracture have taken place in the median line of the occipital bone, or should there be two or more lines of fracture diverging towards the foramen magnum from a point in the middle line, the extravasation may appear on both sides at a varying interval."—*British Medical Journal*, July 12, 1890.

**A RENAL CALCULUS WITH AN UNUSUAL NUCLEUS.**—Kendall Franks, reports what is probably a unique case, where after an unsuccessful operation for renal calculus, he found a stone in a peri-renal abscess, the nucleus of which was the pointed half of an ordinary sewing needle, which he ascertained the patient had swallowed some 17 years previously.—*British Medical Journal*, July 5, 1890.

**SUCCESSFUL TREATMENT OF INTUSSUSCEPTION BY INJECTION OF AIR.**—Drake, reports the case of a child 7 months old, who while playing, suddenly fell back in a fit, screaming with pain. The patient when first seen was in a state of collapse, constantly vomiting and evidently in great pain. Some six hours later the condition continued, with blood and mucus discharging from the anus without fecal matter. Careful examination revealed a sausage-like tumor in the right hypochondriac region, evidently connected with the intestines and most distinctly an intussuscepted gut. Various remedies having been tried without effect, the bowels were carefully inflated with air by means of an ordinary small pair of drawing-room bellows, when in a few minutes the intussuscepted bowel was suddenly felt to have disengaged itself. The countenance of the child immediately changed, the collapse, vomiting, and discharge of blood and mucous gradually subsided, and a loose stool was voided in a few hours. The child made a rapid recovery.—*British Medical Journal*, July 5, 1890.

**TREATMENT OF HÆMATURIA FROM PROSTATIC ENLARGEMENT.**—Harrison, in a series of one hundred cases of hæmaturia, attributes twenty to senile prostatic hypertrophy. The bleeding as a rule is not very great, but recurs from time to time on the slightest provocation, such as cold and fatigue. Some have temporary attacks of bleeding much on the same principle as others do who suffer from piles, which condition is known by German writers as prostatic piles. In cases where the bladder is capable of emptying itself, this symptom is merely a temporary one and usually disappears with some restriction in diet and a little active purgation. In cases of enlarged prostate with an atonic bladder there is always more or less trouble connected with this kind of bleeding, the great safeguard against prostatic hemorrhage being the power the bladder has of contracting and thus exercising pressure. In these cases hæmostatics are of no avail; the mechanical reason why the bleeding will not cease must be recognized and acted upon. For the purpose of emptying the bladder in such cases, there is nothing like use of the catheters and aspirators which are employed in lithotomy. Unless this is effectually done, there is little chance of restraining the hæmorrhage.—*Medical Press and Circular*, July 23, 1890.

**ANÆSTHESIA.**—In an address before the Tenth International Medical Congress, held at Berlin, Wood, after carefully detailing the results of his experiments with ether and chloroform arrived at the conclusion that chloroform and ether are capable of paralyzing the respiration and the circulation; that in some cases one function, in other cases the other function, is primarily arrested; but that ether is less prone to produce a primary arrest of the heart than is chloroform; that certain general facts or principles in regard to anæsthesia must be considered as established.

First.—The use of any anæsthetic is attended with an appreciable risk, and that no care will prevent an occasional loss of life.

Second.—That chloroform acts more promptly and much more powerfully than ether, both upon the heart and respiratory centres.

Third.—The action of chloroform is much more persistent and permanent than that of ether.

Fourth.—That chloroform is capable of causing death either by primarily arresting the respiration, or by primarily stopping the heart, but that commonly both functions are abolished at or about the same time.

Fifth.—Ether usually acts very much more powerfully upon the respiration than upon the circulation, but that occasionally, and especially where there is a feeble heart action, ether is capable of acting as a cardiac paralyzant, and may produce death by cardiac arrest at a time when the respirations are fully maintained. Proportionately, chloroform kills four or five times as frequently as does ether.

In discussing the treatment of the accidents of anæsthesia the author has found by a series of experiments, that of the most frequently used remedies ether, alcohol, ammonia, nitrite of amyl, digitalis, atropine, and caffeine, only the digitalis, and ammonia are of real value, but perhaps the most useful in chloroform poisoning is strychnine. Artificial respiration, however, surpasses all other means for the restoration of life. The author is strongly in favor of the use of forced respiration as practiced by Fell.—*Medical News*, August 9, 1890.

**EXCISION OF A PORTION OF THE LIVER.**—At Albert's Clinic in Vienna, Hoch-negg removed a gall bladder containing fifty-two stones, the walls being carci-

nomatous; the liver was carefully examined for metastasis. But one metastatic deposit was found near the anterior border of the organ; this was removed and the peritonæum was sown around the wound, after which the abdomen was closed in such a manner as to allow inspection of the wound in the liver. The portion removed was one by one and one-half inches in size. It is now over nine months since the operation, and no recurrence. The case is interesting because it is believed to be the first where a neoplasm has been removed from the liver successfully.—*Medical News*, July 26, 1890.

**A POWERFUL ANTISEPTIC.**—Potassium mercurio-cyanide ( $\text{KHgCy}_4$ ) is one of the most powerful antiseptics known. Behring found that one part in 60,000 will entirely prevent the development of the anthrax bacillus in serum. It is soluble in water and does not precipitate albumin. The lethal dose for Guinea pigs is 1—150,000 of the weight.—*Medical and Surgical Reporter*, August 9, 1890.

**TREATMENT OF TUBERCULOUS JOINTS AND COLD ABSCESSSES BY IODOFORM INJECTIONS.**—At a recent meeting of the German Surgical Association, Bruno recommends iodoform injections in the proportion of 1 part iodoform to 10 or 20 parts of olive oil or glycerine in cold abscesses and tubercular joint disease, as the iodoform coming in more or less permanent contact with the tubercular granulations, heals the local troubles. After aspirating the abscess cavity he injects a freshly prepared and sterilized emulsion of the above, repeating it as often as thought necessary. After several weeks of this treatment the cavity gradually grows smaller until at the expiration of from 2 to 4 months the trouble has entirely disappeared. Of 100 cases treated at the Pübingen Clinic, including ten cases of abscess resulting from caries of the spine, 80 per cent. were cured. The author also recommends the above treatment in cases of tubercular empyema.—*Centralblatt für Chirurgie*, June 21, 1890.

**INJECTION OF FILTERED AIR IN THE DIAGNOSIS OF RUPTURED BLADDER.**—Keen believes the following method to be of great service in determining the presence of a rupture of the bladder.

First.—Introduce a catheter and empty the bladder of the urine that it may contain.

Second.—The catheter is now connected with the ordinary Davidson's syringe, which has been thoroughly disinfected. The distal end of the syringe is covered with a mass of absorbent cotton.

The cotton prevents the entrance of germs, the same as in culture tubes. Air is then pumped into the bladder. In case no rupture is present, the rounded, elastic tympanitic bladder will appear in the hypogastrium. Should a rupture exist, the air will escape through the rent into the general peritoneal cavity, and distend the entire belly. The author has, as yet, not had an opportunity of applying the method in the living.—*Annals of Surgery*, July, 1890.

**THE STERILIZATION OF CATGUT.**—The present method in vogue of preparing catgut proving not efficient as most surgeons can testify, Fowler, after a series of carefully conducted experiments has come upon a method which in all probability will prove efficient without affecting the integrity of the catgut. His method is as follows:

The raw catgut of commerce is simply boiled for one hour in 97 per cent. alcohol, the boiling point of which is  $187^{\circ}\text{F}$ . It is afterwards preserved in the same fluid; this seems to increase the strength of the gut, and lessens the tendency of the strands to slip through the hands while tying; also the knots are not as liable to become loosened. The author also believes the gut to become less rapidly absorbed. As to the steps of the method of preparation, Fowler has found that a pint of alcohol is sufficient for sterilizing fifty metres of catgut. The latter is wound upon an ordinary spool and placed in a small fruit jar, or ground glass stoppered bottle, the cover or stopper being left loose or removed, and the necessary amount of alcohol poured over it. This is then placed in a water-bath or one of the steam milk sterilizers in common use, or any method of boiling the alcohol may be employed. Should the gut become reinfected by handling or otherwise, it may be re-sterilized by again boiling it without impairing its texture.—*Medical Record*, August 16, 1890.

**TREATMENT OF OBSTINATE CONSTIPATION BY DILATATION OF THE ANUS.**—In the *Annales de Therapeutique Medico-Chirurgicales*, March, 1890, Monod relates in detail

the history of two cases, in which this operation was performed with marked success. In the first case, a woman, forty-five years old, had suffered for some years with digestive troubles, which she thought were due to a tumor of the bowel. Digestion was disturbed by swelling of the belly and eructations, with a feeling of weight in the lower part of the abdomen, and with constipation alternating with diarrhoea. On examination of the rectum, Monod found that the tumor was an enormous lump of hardened feces, the presence of which had not been suspected, because there had been no sign of obstruction of the bowels recognizable by the patient as the fecal matter, rendered fluid by repeated purgatives, slipped over the hard mass. After dilating the anus instrumentally, the mass referred to was broken up with the fingers and removed, together with a vast number of scybala. A laxative given in from twenty-four to forty-eight hours, completed the clearing out. As six years have elapsed since the operation, and the patient has had no return of her troubles, there is some ground for regarding it as curative. Of course, however, careful instructions were given, regarding the regulation of the diet.

In the second case, a woman, fifty years of age, suffered with habitual constipation and various digestive troubles brought about by it. The use of repeated injections and laxatives, or, in their absence, the passage through the rectum of hard, fecal matters, had induced a condition of habitual irritability of the anus, never, however, amounting to the cutting pain of fissure. Monod dilated the anus and the patient's distressing symptoms disappeared, and gradually she was able to do without laxatives.

Monod says, these are not the only cases of the kind he could cite. They are sufficient, however, to illustrate the fact that some cases of constipation depend on a local removable lesion of the lower part of the rectum and of the margin of the anus, which can be remedied by dilatation. This treatment must necessarily have a limited range of applicability, but it certainly appears worthy of consideration in the management of cases in which constipation is the result of habitual spasm of the sphincter ani, set up by hæmorrhoids, fissure, eczema, or—as apparently in the first case—by an impassable ball of hardened feces.—*Medical Age*, July 10, 1890.

**CASE OF COMPLETE PARAPLEGIA CURED BY OPERATION.**—At the recent meeting of the American Neurological Association, Dr. F. X. Dercum presented a middle-aged man with the following history in brief: The patient had, in 1887, suffered severe pain in the arms and shoulders. The pain had appeared to be referred to the principal nerve tracts. Soon after this he lost power in his legs. Then about October, 1888, in addition to the paraplegia, there was loss of sensibility with constricting pains about the upper portion of the chest. There was also complete paralysis of both sphincters. Examination had revealed the fact that the man's back was quite painful over the third, fourth and fifth dorsal vertebræ. Thinking that there might be some local cause for the paralysis, Dercum called others in consultation. It was agreed that the case was one in which trephining should be tried. The spines of the arches of the first to the fifth dorsal vertebræ inclusive were accordingly removed. The dura was found somewhat abnormally resistant to the touch, and was opened. Adhesions existed between the dura and pia. After the operation, which the man had borne well, he had at once said that his pain was absent. A few days afterwards he was able to feel at the foot when touched. Then he was sensible that his hands were cold, and was able in a few days more to move his toes. There had been a very gradual and steady progress towards complete recovery. He had also regained control of his sphincters. Whether the result was to be attributed to local relief from pressure or to reaction from shock of the surgical operation, the speaker did not venture to suggest. The paraplegia was probably the result partly of pressure and partly of myelitis.—*Journ. of Mental and Nervous Diseases*, August, 1890.

**TREATMENT OF VARICES WITH COAGULATING INJECTIONS.**—For the purpose of curing varices, Dr. D. Molliere uses the following solution: Pure iodine, 1.0; tannin, 9.0; distilled water, 10.0. This fluid when injected does not cauterize, but merely coagulates the blood. The patient must walk about for a half-hour before the operation in order that the varices may swell up. A bandage is then applied below the point of injection. He then injects with a syringe having a double canula a few drops of the solution into the dilated vein. The point of puncture is then covered with iodoform collodion. The constricting bandage is allowed to remain. The patient keeps at absolute rest for fourteen days.—*Lyon Medical*, 13, 1890.



# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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CONDUCTED BY

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**BRITISH MEDICINAL PLANTS.**—In the August *Homœopathic Physician*, Dr. Alfred Heath continues his description of British medicinal plants, from which we excerpt as follows:

*Helleborus Viridis*.—Produces, among other symptoms, ringing and roaring in the ears, with feeling of stoppage; violent itching in the nose, with frequent and violent sneezing, from application to the parts, pricking on the tongue, relieved by rinsing with water. At first a profuse secretion of saliva and mucus in the mouth, soon followed by a feeling of dryness and of warmth in the pharynx and stomach, which gradually becomes a dull burning. Abdomen sensitive and distended. Profuse diarrhœa, with intense colic and tenesmus. Great nausea and inclination to vomit. Violent headache and thirst. A condition bordering on torpor, lasting the whole night and preventing refreshing sleep. Heat at times over the whole body.

*Helleborus Fœtidus*.—The leaves are said to have extraordinary powers as a remedy for worms. The root is fetid, has a bitter taste, and is so acrid that, if chewed, it will excoriate the mouth. It is purgative or emetic, and very injurious in large doses. It produces violent vomiting and purging, with pain in the stomach, soreness of the mouth and throat; colic, fatal convulsions and swooning; falling off of the hair and of the nails of the fingers and toes; peeling of the scarf-skin of the whole of the body; restless sleep; profuse discharges from the ulcerated surfaces by applying the drug; difficulty in reading in the evening by candlelight for four days.

*Helleborus Niger*.—The ancients esteemed this plant as a powerful remedy in mania. In more recent times it has been used as a drastic purgative, and in smaller doses as a diuretic and emmenagogue, also in mania, coma, dropsy, worms and psora. It produces melancholy; taciturnity; excessive and almost mortal anguish; nostalgia, attended with melancholy, loss of appetite and sleep; indolence; sobbing; lamentation; obtinate silence; mistrust; stupidity; weakness of memory; involuntary watery diarrhœa, colic, urging, straining and vomiting; suppression of the menses; drowsiness, constant somnolence, torpid sleep; ulcers and various skin troubles; suppression of urine, over-distension of the bladder, frequent urging to urinate, with scanty discharge; sudden, watery swelling of the whole body, anasarca.

*Aquilegia Vulgaris* (Columbine).—Formerly employed for eruptions of the skin, jaundice, scurvy. It is very similar to secale cornutum in its action in child-birth. It is used in Spain as a remedy for stone.

**ACCIDENTAL PROVING OF ATROPINE.**—"Carl, the two and one-half year-old child of Dr. H. S. Reincke, dentist, at 4 P.M. took a portion of a teaspoonful of solution of atropine, two grains to the ounce. At half-past 5 found him with: Pupils widely dilated; face and whole body scarlet red, with peculiar white spot on pressure; very hot, no thirst; mental condition one of great excitement; sudden crying out as if pained and frightened; pushing himself away from his mother; after being quiet for a moment would kick vigorously with feet and jerk the hands and arms, and begin a fretful cry, which would last for a few minutes, when it would subside; inability to sleep; moist skin; frequent urination toward 4 P.M. Symptoms began to

subside about 5 A.M. Would sleep for half an hour, then wake with crying spell: redness of skin continued some thirty-six hours; constipation (unusual for this child) followed."—Dr. Z. T. Miller, *Medical Advance*, August.

**PROVING OF JACARANDA GUALANDAI.**—"Dr. Jose M. Reyes, of Bogota, S. A., twenty-one years of age, at the request of Dr. J. F. Convers, took the mother tincture and dilution of gualandai. On the 2d and 3d of January, 1895 he took twelve drops of the tincture, prepared from the dry leaves, and he only felt at night pain between the sacrum and coccyx. On the 4th he took twenty-six drops and only felt vertigo on raising the head after stooping, with momentary loss of sight and weight on the forehead. On the 5th he took two grammes twice a day, and he continued taking the same dose until the 9th without feeling but a diminution of memory. On the 10th he commenced to take five grammes twice a day, and on the 11th a diarrhoea, of a dark mulberry color, made its appearance, which persisted until the end of the proving. On the 13th he took ten grammes without any other symptoms than an increase in the diarrhoea. From this date until the 16th he took ten grammes every twelve hours, with only the mulberry-colored stools, debility of memory and a great deal of pain in the glans penis. On the 24th of February he began to take the 3x dilution, twelve drops every twelve hours, and on the following day he experienced pain and irritation in the eyes, which became red, with a sensation as if there were sand between the lids and the ball of the eye. The ophthalmia was worse in the left eye; but both eyes became agglutinated during the night by the excessive secretion of the meibomian glands. After two days he felt pain in the larynx on reading and on laughing, and swelling of the left tonsil. On the 23th he discontinued the experiment, getting slowly better of everything except the diarrhoea. On the 2d of March he again took the 3x, with a reappearance of the ophthalmia. To cure the diarrhoea arsenic 12 was insufficient, but it disappeared under mercurius solubilis."—*Homœopathic Recorder*, July.

**ACCIDENTAL PROVING OF STRAMONIUM.**—Dr. Z. T. Miller, in the August *Medical Advance*, relates the following: Boy, eight years old, ate some stramonium seed. Complained first of dryness of throat, then followed—pupils dilated, eyes bright, skin cool. Hilarious laughing. Sudden jerking of head to one side as if to see something. Imagined he had a sore finger, and motioned as if he were unwrapping a rag that he thought was bound around it. Would answer questions irrelevantly, then laugh and engage himself with his hallucinations. Fear or fright at some imaginary thing or person was ever present. Symptoms lasted from 4 P.M. until next morning.

**ANTHRAX AND ANTHRACINE.**—Dr. P. Dufresne, of France, is publishing in *L'Art Medical*, a series of articles under the heading of "Histoire de l'Homœopathie," mostly taken from the life of his father. After reviewing the disease known as anthrax, he states that in 1834, a farmer, aet. 40, came under the care of his father. Symptoms: considerable swelling in the left cervical region; at the centre a tumor surmounted by a gangrenous areola and surrounded by a vesicular eruption. General condition bad, prostration, fever, cold, sweats, etc. Diagnosis: Anthrax. He gave *anthracine* 10x dil. internally, using at the same time cold applications of alcohol and anthracine. The next day an amelioration began. In two weeks the patient was presented to the meeting of the Société Gallicane and in a few days more was completely healed and cured. Again, in 1836, two brothers, shepherds, came to Dr. Dufresne both having contracted anthrax from sheep. Notwithstanding that the tumor in one case had been incised and cauterized with sulphuric acid, it had reappeared surrounded with new vesicles. In the other case, the disease showing itself later, no cauterization was done. *Anthracine* was used internally and externally in the same dilution. Not only were both cured in five days but Dr. Dufresne collected the fluid from the pustules of one of the patients and after having dynamized it, gave orders to administer this to the infected sheep, as it had been stated that the disease was making terrible havoc in the flock. Since its administration no sheep were lost.

**BELLADONNA IN HEADACHE.**—Dr. C. E. Fisher reports the cure of a headache occurring in a little girl after mental excitement with a single dose of *belladonna* 3x. Iris had been given for an hour unsuccessfully under the supposition that the headache was gastric in origin. Symptoms: Face pale and cool; hands and wrists cold and clammy; headache slightly relieved for a moment by pressing against the table,

or other hard substance; pain or ache confined to the forehead or top of head; pain so intense as to cause the patient to cry out.—*Southern Journal of Homœopathy*, June.

**REMEDIES FOR TRAUMATIC DETACHMENT OF THE RETINA.**—For this affection, Dr. Daniel Parenteau says he has found atropinum sulph., glonoine and lachesis the most efficient remedies.—*Revue Hom. Française*.

**PHOSPHORUS IN PAIN BENEATH STERNUM.**—Mrs. F. suffers from a pain beneath the middle of the sternum since walking rapidly against a west wind three months ago. It is felt as well while she is sitting down as when she is in motion. Sensitiveness to pressure is found where the pain is felt. Pulse rapid, but no other abnormality can be found by the most careful examination. After receiving *phosphorus* 6, she remained free from the pain for two weeks when the pain and sensitiveness to contact returned. With the pain she has a sensation as though gas would rise from epigastrium. *Phosphorus* 3. In a week all traces of her ailment had disappeared.—Dr. Kunkel in *Allgem. Homœop. Zeitung*, July 24, 1890.

**AURUM IN APHTHÆ.**—Mrs. F., æt. 30, has been suffering since her twentieth year with aphthæ which develop in the mouth, on the hard palate and on the tongue. Frequent bad taste, bad smelling breath, constipation, much mucus in mouth, R. *Aurum*, 3, a dose morning and evening.—Nine days later she reported herself cured.—Dr. Kunkel in *Allgem. Homœop. Zeitung*, July 24, 1890.

**SOME REMEDIES FOR THE NOSE, THROAT AND LARYNX.**—From an article in the *July Journal of Ophthalmology, Otology and Laryngology*, on "Therapeutics and Clinical Data of Diseases of the Nose, Throat and Larynx," by Dr. J. A. Terry, we abstract the following:

*Cinnabaris*.—*Pathological Indications*: Chronic and sub-acute nasal catarrh. Syphilitic rhinitis. Post-nasal catarrh. Ozena. *Clinical*: Lumps of dirty yellow mucus are discharged from the posterior nares. Coryza, with lameness of the thighs and aching in the small of the back. Nasal catarrh, sub-acute and chronic, with pain about the root of the nose, extending into the bones on each side. *Characteristic*: Sensation on bridge of the nose as if touched by a metal. Uneasy creeping and pressive sensation about ossa nasi, as from heavy spectacles (compare kali bichromicum.)

*Corallium Rubrum*.—*Pathological Indications*: Coryza. Epistaxis. Ulceration of wing of nose (right.) Post nasal catarrh. *Clinical*: Painful ulcer in right nostril, sensation as if the nasal bones were pressed asunder. Violent coryza, discharge resembling molten tallow. Profuse secretion of mucus through posterior nares, obliging to hawk frequently. Epistaxis from one side (at night) (calcareæ, right side).

*Elaps*.—*Pathological Indications*: Naso-pharyngeal catarrh. Epistaxis. Obstruction. Ozena. Anosmia. Fluent coryza. Chronic rhinitis, plugs and scabs. *Clinical*: Subject to nosebleed, eruption about nose, pain in nose and forehead, skin dry and hot, but complains of feeling cold. Stoppage of nose high up and dull aching in forehead, bad smell in nose, pharynx scabby, cracked and dry; nosebleed, pain from root of nose to ears on swallowing, no smell. Chronic ozena and nasal catarrh complicated with obstruction in breathing, plugs of dry mucus, scabs greenish or blood-streaked, pain at the root of the nose, and anosmia.

*Graphites*.—*Pathological Indications*: Ozena. Eczematous eruptions (moist.) Tendency to fissures and cracking of the skin. Herpetism. Tendency to obesity. Erysipelas of the face, with ulcers about the nose and mouth. *Clinical*: Nasal catarrh, frequently with dryness of the nose, but great soreness, with formation of scabs, a kind of ozena with bad odor, the nostrils externally ulcerated, cracked in the corners and bleeding. Eczema about the nose and mouth, with cracks in the corners of the lips and wings of the nose. Pimples or comedones on nose. Black pores. *Characteristic*: Smell acute, cannot tolerate the smell of flowers.

*Hydrastis*.—*Pathological Indications*: A catarrhal drug, with affinity for the mucous membranes, with profuse discharges and ulcerations. In scrofulous children attained with marasmus. Diphtheria of the nose (locally applied). *Clinical*: Nasal discharge, watery, excoriating, with burning, rawness of the throat. Catarrh mostly in the posterior nares, with obstruction, headache, and the discharge dropping in the pharynx. Ozena with bloody discharge; ulceration of the septum nasi, easily bleeding when touched. Yellow, greenish, offensive discharge in hypertrophic

catarrh. *Characteristic*: Discharge of thick yellow matter. The thick, tenacious secretion from posterior nares dropping into the pharynx.

*Iodium—Pathological Indications*: Scrofulous constitutions. A swollen, painful nose accompanies generally the internal inflammation in chronic cases. The mucous membranes are as much affected as the glandular system. *Clinical*: A very valuable remedy in acute fluent coryza; the discharge is hot, the nose becomes sore, headache at the root of the nose and over the frontal sinuses. The attack is attended with sneezing, fever, etc. In sub-acute and chronic catarrhs, discharge foetid, nose swollen and painful. Catarrh of the nose and Eustachian tubes, with thin, white discharge and stoppage of the nose. *Characteristic*: Coryza, nose stopped up, worse evening, being fluent in open air. Fluent coryza, glassy mucus, fluent like water, with much sneezing.

**REMEDIES FOR THE TREATMENT OF PULMONARY PHTHISIS.**—Dr. P. Jousset, in speaking of the remedies for this affection, refers to the following: "Drosera, which in animals, provokes chronic cough with loss of flesh and even tubercles, becomes a therapeutic agent to calm the cough, increase the strength of the patient and institute a continuous improvement in the general condition. It should be employed in quite large doses, either the plant extract or twenty-drop doses of the tincture. Even if the drosera does not cure, it has a very certain palliative action, especially when the cough is paroxysmal and when accompanied by tickling in the throat and vomiting. It has a decided action. In ninety-seven cases out of one hundred, the cough lost its spasmodic character and the titillation disappeared. . . . The treatment by iodide of arsenic, 6th dil., and phosphate of lime, 6th dil., praised by Dr. Martiny, has also given good results. One remedy is given twice one day, and the other twice the second day. Dr. Jousset recommends arnica, aconite, millefolium and ipecacuanha for hæmoptysis; hyos. nig. for the nocturnal cough and tickling in the throat; phos. acid for the debilitating diarrhoea, and silica, high, for the hectic fever.—*Rev. Hom. Belge*, No. 11, 1890.

**CONIUM MACULATUM IN COUGH.**—Dr. J. Murray Moore, in the August *Monthly Homœopathic Review*, reports a number of cures of "irritative uvular throat cough," with conium maculatum.

**A CONIUM COUGH CONFIRMATION.**—Dr. R. C. Markham has twice, in the treatment of coughs, verified the conium symptom: "*Beating stitch*, with pain in the upper and left part of the chest, toward the centre of the chest."—*Medical Advance*, August.

**CLINICAL CONFIRMATION OF CONIUM COUGH SYMPTOM.**—Dr. J. Murray Moore reports the cure of the following conium cough symptoms, in a series of cases: (1.) Frequent hawking of mucus; (2.) Itching in the throat, with irritation to a hacking cough; (3.) Scraping in the throat, with cough at night; (4.) Cough almost only when first lying down, during the day or evening; he was obliged to cough it out, after which he had rest; (5.) Much tickling in the throat, with provocation to dry cough while sitting; (6.) Cough as from tickling in the middle of the sternum, with and without expectoration; (7.) Whooping cough and dyspnoea; (8.) Cough very much aggravated by lying down; in the beginning, many shocks of coughing as if he would vomit; constant severe cough in the evening on going to sleep.—*Monthly Homœopathic Review*, August.

**A NEW INDICATION FOR KALI BICHROMICUM.**—Dr. John Storer, after reciting the cure of a chronic case of asthma, always brought on by coitus, with *kali bichromicum* cm. says: "I know of no remedy that has 'asthma caused by and always followed by coitus.' Kali bichromicum certainly relieved the symptom."—*Medical Advance*, August.

**CORALLIUM RUBRUM IN ASTHMA.**—Dr. J. A. Terry cured, with corallium 30, a case of chronic asthma in a phlethoric and sanguineous woman, with dry, spasmodic cough, glairy expectoration and subject to posterior nasal catarrhs with one-sided epistaxis. The case has remained well up to date.—*Journal of Ophthalmology, Otology and Laryngology*, July.

**KALMIA FOR SYMPTOMS DUE TO MITRAL DISEASE—AN EXTRAORDINARY CASE.**—Dr. Proëll in *Revue Hom. Belg.* No. 10, records the case of a boy, 13 years, who suffered very much from headache and weakened memory, so that he was

unable to continue his studies, the condition proceeding from insufficiency of the mitral valves. *Kalmia latifolia* 1 cent. dil., was given three times a day. Slight improvement followed after three days, and in seven days great amelioration was noted. The remedy was discontinued three days, when it was resumed in the 2d cent. dil., morning and evening, with very rare recurrences of the headache. The *kalmia* was then given in the 3d each morning for seven days. Complete subsidence of the symptoms followed, notwithstanding the persistent organic heart lesion. The remedy was only used two months: now, seven months from that time, the boy continues his studies without annoyance.

#### ACTION OF SYZIGIUM JAMBOLANUM UPON ARTIFICIALLY-PRODUCED DIABETES.

—Dr. Graeser has made some experiments in the laboratory of Professor Binz at Bonn, with the extract of this drug. He gave 2.5 gr. to 4.8 gr. of *phloridzine per diem*, to young dogs, weighing 2 kilo. 700 grammes to 4 kilo. 800 grammes. In the proportion of 1 gr. per kilogramme weight of each dog. He was thus able to produce excretion of sugar amounting from 589 gr. to 1 kilo. 245 gr. in 24 to 36 hours.

In every case of artificial diabetes *syzigium jambolanum* caused the quantity of sugar to diminish in a proportion of  $\frac{2}{3}$  of the quantity excreted and the duration has been equally reduced. Those researches demonstrated also that *syzigium* could be employed in sufficiently large doses without any trouble. The daily dose in this case has been 16 to 18 grammes.—*L'Art Medical*, August, 1890.

**ROBINIA IN DYSPEPSIA.**—"Robinia has, in my hands, often cured a group of dyspeptic symptoms, differentiated by the intensely *acid* or *sour* eructations of fluid. The symptom, 'The fluid vomited is so sour that the teeth are set on edge,' may be regarded as a keynote for robinia pseudo-acacia."—J. Murray Moore, *British Monthly Homœopathic Review*, August.

**ANTIMONIUM CRUD. IN WEAK DIGESTION.**—K, male, æt. 70, complains of weak digestion; must avoid potatoes, cooked meat and peas. Cannot stand the heat of the sun or moist and warm weather. Occasional attacks of sleepiness during the day. Tongue moderately coated. At times has great thirst and desire for sour drinks. R. antim. crud., 10, a dose every seventh day. Rapid improvement set in, and ultimately he was entirely cured.—Dr. Kunkel, *Allgem. Homœop. Zeitung*, July 24, 1890.

**REMEDIES FOR CONSTIPATION.**—In the *July Medical Advance*, Dr. H. P. Holmes, says: Among the many remedies useful in the treatment of constipation, I will give what I consider the twelve principal ones: *Æsculus*, *alumina*, *bryonia*, *calcaria*, *causticum*, *graphites*, *lycopodium*, *natrum muriaticum*, *nux vomica*, *opium*, *sepia* and *silica*.

*Æsculus* is useful in those cases attended with piles, prolapsus ani and pruritus. Constant, ineffectual urging to stool; the stools are large, hard, dry and dark; dryness, heat and constriction in the rectum, which feels as if full of sharp sticks. The last of the stool may be of the proper consistency, followed by burning and constriction of the rectum. Severe *lumbo-sacral backache*.

*Alumina*.—The keynote of this remedy is *torpor*. *Atony of the colon and rectum*. Inactivity of the rectum, even a soft stool requires great straining. There is no desire for a stool, nor an ability to pass one until the bowel is loaded full. Stools hard and like putty, sticking to the rectum. The passage from the rectum may be accompanied by blood, while the straining at stool causes a flow of urine. Long-lasting pains in the rectum after stool. *Alumina* is useful in the constipation of old people, and in our most stubborn cases where *torpor* or *atony* of the parts is the principal symptom.

*Calcaria*.—The stools are dry, knotty, difficult, of a chalky appearance. Frequently indicated in children, especially during dentition. Hard, large, partially undigested stools. There is, at times, an oozing of fluid from the rectum smelling like herring-brine. Useful in *leuco-phlegmatic* people; tissues flabby, white complexion or very fat people. Always feels best when constipated.

*Causticum* is of great service in the constipation of children, accompanied by enuresis nocturna. The stool is tough, greasy or shiny, accompanied by a greasy taste in the mouth. Dryness of the rectum; the stool passes better when standing. Frequent, ineffectual urging to stool, anxiety and redness of the face.

*Graphites*.—Hard, knotty stool, united by strings of mucus, or covered with mucus.

Dryness of the rectal mucous membrane, with fissure of anus. A quantity of white mucus is discharged (like aloë). *Herpetic diathesis*.

*Lycopodium* has its characteristics in a small stool, with sensation as if much remained behind, with large accumulation of gas in the bowels. Desire for stool, with inability. Useful in the constipation of elderly people. Abdominal plethora. There is the characteristic backache of *lycopodium*, accompanied by brickdust sediment in the urine.

*Natrum Muraticum*.—Obstinate constipation, with troublesome perspiration on slight movement. The stools are hard, difficult and crumbling; difficult expulsion of feces, leaving a sensation of great soreness at the anus. It tones up the intestinal mucous membrane.

*Nux vomica* is the great remedy for constipation. It has its keynote in *frequent ineffectual desire for stool*; the patient goes often enough, but accomplishes nothing, or with great difficulty. Stools black and hard, often streaked with blood. Hemorrhoidal diathesis, and in dyspeptics. Useful in those cases that have been much drugged, addicted to the use of stimulants or to the abuse of highly-seasoned foods. It is a good medicine with which to begin a case coming from old-school treatment. There is an obstructed portal circulation and great relief from stool.

*Opium* will be occasionally called for. The stools are *small, hard, round, black balls*. In such cases we usually find the copraemic complexion, as the moisture is all absorbed from the feces. Useful in higher potencies where there is a history of *opium drugging*. Constipation causes very little inconvenience. It is indicated in the constipation of *good-humored, corpulent women*. Also useful in obstruction of the colon.

*Sepia*.—Stools *hard and small like sheep's dung*. Ineffectual urging, with tenesmus, *earthy complexion*, bilious looking. The best remedy in cases of copraemia. Constipation during pregnancy. Difficult to pass even a soft stool. Prolapsus ani during stool (compare *ignatia*). Useful in women where there is inactivity of the colon and rectum.

*Silica* finds its keynote in constipation when the stool, when partly passed recedes into the rectum. Even a soft stool is passed with difficulty. Stools of hard lumps, which remain long in the rectum. Much rumbling in the rectum.

ARSENICUM IN CHRONIC DIARRHŒA.—Dr. S. H. Hallock, in the *Medical Advance* for August, relates the case of a child, 2½ years of age, who since birth had had a diarrhœa, the stools varying in number from eight to twelve in twenty four hours. Allopathic treatment had only succeeded in checking the bowels for a day or two. The doctor found a pale, wan, emaciated child, heavy black rings under the eyes, fretting and crying, was having from twenty to thirty evacuations in twenty-four hours, of slimy green mucus; evacuations involuntary, some pain. *Arsenicum* 200 was prescribed; six doses, helped greatly and ultimately cured the patient.—*Medical Advance*, August.

VERATRUM IN SCIATICA.—Mrs. J. M. S., age 43, widow, has suffered with sciatica for four years; pains sharp, transient, darting upwards and downwards from both sides to centre; heat makes pain worse—the cooler the better; attacks with cold perspiration; headache from both temples to base of brain, aggravated by heat, vertex itches during attacks; pain compels her to move about, but motion does not relieve. *Veratrum album* 200, one dose, promptly cured.—Dr. W. S. Gee, *Medical Advance*, July.

GOSSYPIUM IN A UTERINE CASE.—Dr. W. D. Gorton cured a case of uterine disorder, with a host of symptoms, with *gossypium* 5. The peculiar symptom leading to the prescription of *gossypium* was "intermitting pains in the ovaries."—*Medical Advance*, July.

SULPHUR IN RHUS POISONING.—Dr. A. McNeil, cured in his own person, rhus poisoning, after several remedies had failed, with sulphur c.m., two doses.—*Medical Advance*, July.

BIARIUM MURIATICUM IN ANEURISM OF THE SUBCLAVIAN ARTERY.—Dr. R. A. Bailey, in the *July Southern Journal of Homœopathy*, reports the rapid cure of an aneurism of the sub-clavian artery, in a very short time, with the 2d decimal trituration of *barium muriaticum*, three doses daily (about ⅓ of a grain).

# THE HAHNEMANNIAN MONTHLY.

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## CASES OF ABDOMINAL SURGERY.

BY WILLIAM B. VAN LENNEP, A.M., M.D., PHILADELPHIA.

(Read before the Homœopathic Society of the State of Pennsylvania, September 17, 1890.)

IN looking over my abdominal work for the past year with a view of preparing a clinical report on the subject, it seemed to me that, instead of attempting an account of all the sections done, it would save time and, I trust, be more interesting to select only those cases that present peculiarities out of the usual run.

Of eight sections for tumors three will come under this category:

(1) *Enormous Fibro-Cystic Tumor of the Uterus; Hysterectomy.*

Mrs. B., age 44, operated for Dr. E. M. Howard of Camden, N. J., October, 1889. For six years has noticed enlargement of the abdomen; it was then about the size of pregnancy at term; the growth was slow at first, rapid of late; there was distinct fluctuation; the length of the uterine cavity was normal and turned to the right; the menses long lasting but not profuse. Section showed a cyst covered by uterine tissue and continuous with the uterus. Tapping failing to empty it, an incision was made, and its structure found to be a mass of small cysts filled with a slightly gelatinous fluid. As this did not materially decrease its size, the abdominal opening was enlarged almost to the ensiform cartilage, and the tumor turned out. An Esmarch tubing was then thrown around the cervix and the tumor, uterus and appendages amputated as low down as possible. A V-shaped piece was taken out of the stump and the flaps brought together by a continuous suture, layer by layer. After

the tubing was removed interrupted sutures were applied to any bleeding points. The abdominal wound was closed, leaving room at its lower angle to draw up the stump, to which the peritonæum and then the skin were stitched. She made a good recovery, some of the stump sloughing, until now only a very small cicatrix remains. She has been in excellent health ever since, barring the annoying and characteristic symptoms of the climaxis.

These large, fibro-cystic uterine tumors are of sufficient rarity to warrant their being recorded, and are usually operated under the impression that they are ovarian cysts. I know of one very able surgeon who, in a similar case, having neither rubber tubing nor écraseur, closed the abdomen without removing the tumor. The method used is, to my mind, preferable to the écraseur, and the suspension of the stump in the abdominal wound has since been advocated by Kelly. It is also less dangerous than dropping the closed stump back into the abdomen. The specimen was presented to our County Society October 10, 1889.

(2) *Multilocular Right Ovarian Cyst; Glycosuria; Excision.*

Mrs. L., age 56, operated for Dr. F. W. Boyer, of Pottsville, Pa., October, 1889. The tumor had been developing for a year; consisted apparently of two cysts, a larger one filling the abdomen and a smaller one the right pelvis. The customary urine analysis revealed a quantity of sugar and a specific gravity of 1045. Section corroborated the diagnosis of two principal, with a number of smaller cysts, containing in all about nine quarts of fluid and springing from the right ovary. A beginning cyst was found in the left ovary, which was tied off. There were no adhesions. The operation occupied twenty-three minutes from the first incision to the completion of the dressing. Recovery was uninterrupted and she was home in less than a month with a marked diminution in the glycosuria. This has since disappeared and has not recurred.

This case fortunately presented no difficulties. The glycosuria, a contra-indication to most capital operations, caused me considerable anxiety, but the rapid growth of the tumor and the inconvenience it was causing decided me in favor of the life-saving operation. This was done as quickly as possible, and the absence of complications during and after it undoubtedly aided in bringing about the favorable result. The disappearance and non-recurrence of the sugar without dietetic treatment would point to the tumor as a probable causative factor.



(3) *Colloid Cyst of Left Ovary ; Peritoneal Infiltration ; Ovariectomy.*

Mrs. V. H., age 58, referred to me by Dr. B. B. Gumpert of this city, and operated April, 1890. The tumor extended to half way between the umbilicus and the ensiform cartilage; was freely movable; there was indistinct fluctation; the uterus was prolapsed and could be separated from the tumor; the cavity was scant three inches long; there was marked cachexia and an induration in the abdominal wall on the left side. After section a quantity of ascitic fluid was let out, and, as the trocar would not evacuate the thick, gelatinous contents, the incision had to be enlarged and the growth turned out. In so doing, although it was handled most gently, the pedicle was torn across. Fortunately my custom of grasping this between two fingers during such manipulations enabled me to control the hæmorrhage that would have followed from the enormous vessels. There was but one adhesion, to the other ovary, in which similar changes were beginning. This was excised, too. A suspicious thickening of the parietal peritonæum was also found on the left side. After thorough douching, the abdomen was drained for twenty-four hours. Recovery was good, barring a troublesome bronchitis. She has since gained flesh, the cachexia has disappeared and now, at the end of nearly six months, there is not the slightest increase in the induration felt in the abdominal wall.

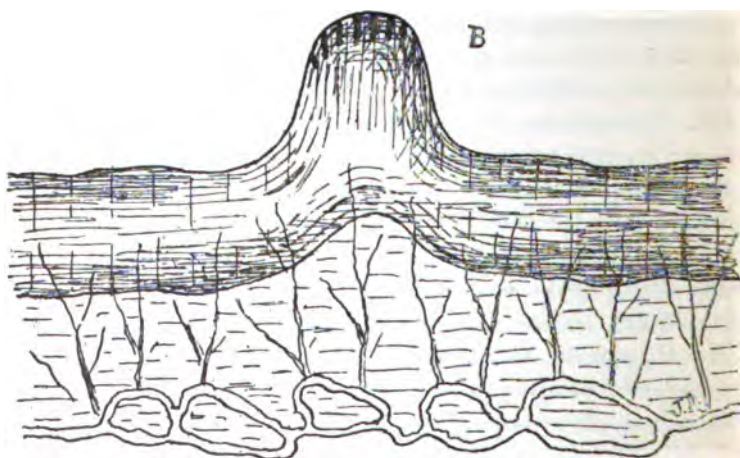
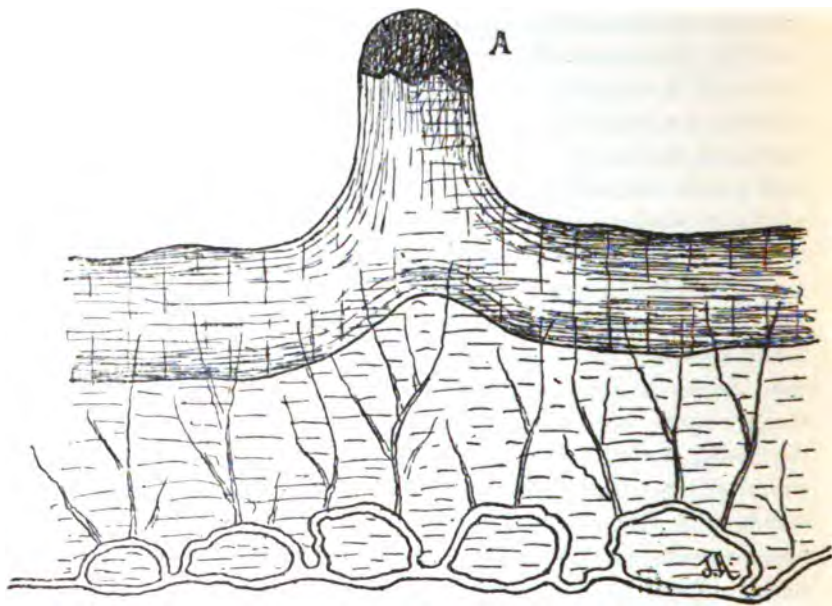
The hæmorrhage, had not the pedicle been under control, must have been terrific, and, if not immediately fatal, would have been arrested with difficulty and might have seriously influenced the result. The question of malignancy and the peritoneal infiltration necessarily suggest recurrence, but so far there has been no sign of such a complication.

I have operated four times during the past year for intestinal obstruction (internal.) One of these cases will shortly be reported by the attending physician, Dr. G. Maxwell Christine.

(1) *Rectal Cancer ; Complete Obstruction ; Inguinal Colotomy.*

Mr. C., age 40, was sent me in the spring of 1889 with the diagnosis of "bleeding piles." Examination showed an extensive rectal cancer, about three inches up the bowel, involving the bladder and the perirectal tissue on every side. Excision, after the method of Kraske-Hochenegg, was suggested, but not urged as it did not offer any prospect of success with such an extensive infiltration. A colotomy, however, was advised before exhaustion and obstruction had worn him out. But his family would listen to no interference

until November, when the hæmorrhages and the progress of the disease having reduced him to a skeleton, complete obstruction had supervened. The abdomen was enormously distended, most



Appearance of intestine after adhesions had been cut loose. A is the raw surface produced; B, the same turned in and the peritonæum united over it.

markedly so in contrast with his general emaciation; stercoraceous vomiting, always so late in obstructions low down, had set in and

nature, in her efforts to afford some relief, had found a vent into the bladder, through which and the urethra flatus and fæces escaped in considerable quantities. A very painful and offensive cystitis was thus added to his other sufferings. The patient being apparently almost moribund, cocaine was used locally and combined with a few whiffs of chloroform. Inguinal colotomy was then performed at the Camden Homœopathic Hospital, after the method of Maydl. The abdomen was opened by a vertical incision with its centre on a line with and two inches inside of the left anterior superior spine of the ileum. The sigmoid flexure was readily found and drawn out, bent until two parallel limbs were formed and held in this position by a couple of stitches. An artery clip was pushed through the mesocolon at the upper angle to suspend the loop on the abdomen and prevent its retraction. The peritonæum was sewed to the skin and then to the intestine and the line of suture covered with iodoform collodion to prevent infection of the abdominal cavity. The gut was then opened transversely with the thermo-cautery and an enormous quantity of fæces and flatus evacuated. Relief followed at once and persistent washing of the distal intestine and bladder removed the rectal and vesical symptoms. Six days later the gut was completely divided with the thermo-cautery, without an anæsthetic and without pain, and the ends trimmed down and stitched to the skin. The distal end of the intestine was made to fill one-third and the proximal two-thirds of the opening. The artificial anus functionated well until the patient died, in about two weeks, of the general exhaustion due to the original disease.

This is the third case operated by the method of Maydl and I must confess to a decided preference for inguinal colotomy over the lumbar incision, as well as for a procedure that will support the intestinal loop, preventing retraction and emphasizing the spur. The operation accomplished all that could have been expected; it was too late to look for prolonged life, but it gave the patient a few more days and a quiet, painless end.

(2) *Acute Obstruction from Flexion due to adhesions of Meckel's Diverticulum; Abdominal Section.*

C. H., age 13 years, operated for an old-school friend, August, 1890. A little over a week before a cow had stepped on the lower portion of the abdomen. Some pain followed and purgatives were freely administered at home; they operated slightly for a day. When seen by his physician, complete constipation had existed for three days and vomiting had supervened. Large injections were

given without avail and, finally, on the sixth day of the obstruction, the parents consented to the operation. There was then projectile vomiting, the ejecta having a decidedly *faeculent* odor; marked prostration, with small, weak, rapid pulse, pallor and pinched expression; a much distended abdomen, which was generally sensitive and slightly dull low down on the right side; frequent attacks of colic, during which the intestinal loops could be distinctly seen through the abdominal wall. Section showed enormous distension of the small intestine and, on allowing a few coils to roll out, a collapsed loop of ileum and the *cæcum* were found under the dull area. The cause of the obstruction was an acute flexion due to a drawing back and twisting of the intestine by a diverticulum (Meckel's), a little over two inches long, attached to the spine. The adhesions, which were old, were divided and the peritonæum drawn together over the raw surface, turning in about one-third of the pouch. This was not excised as the intestinal lumen into which it opened was quite narrow, the surface opposite the broad mouth of the diverticulum projecting toward the latter. (See Fig. p. 644.) A longitudinal incision was made in the intestine above the obstruction and the contents emptied; besides liquid *faeces* there were hundreds of watermelon seeds. This opening was sutured by a running stitch of fine silk, forward and back, and the abdomen closed in the usual manner without drainage. The bowels did not move until the second day, when an enema of glycerine and then a large one of water were followed by an enormous stool with complete relief of pain and distension. They were kept freely open for a few days, to fight adhesions or to have them form with the intestine in a position favorable to its permeability, and have since acted naturally. He has made an excellent recovery.

The youth and vitality of this lad were undoubted factors in his recovery, for the operation was done none too soon. It seems a pity that, in the vast majority of cases of intestinal obstruction, operative relief is left until the patient is practically moribund, but it is to be hoped that the profession will soon be able to educate the public, as they have gradually done in regard to hernial strangulations, to remove this most potent factor in the terrible mortality following what otherwise would be a generally successful operation. This diverticulum usually causes obstruction by forming a band under which a coil of intestine becomes strangulated. A posterior attachment to the spine and a resulting flexion are more unusual. Only the portion of the diverticulum bared of its

peritonæum by dividing the adhesions was turned in to cover the raw surface, as the narrowing of the bowel lumen required this pouch to avoid what otherwise would have been a stricture. The immediate cause of the acute obstruction is a question; the adhesions binding the diverticulum to the spine were undoubtedly of long standing; there were no signs of a recent inflammatory action, so that the traumatism cannot be blamed. Probably the free purgation used by the family, in consequence of the abdominal pain and possible intestinal torpor, so increased the peristalsis or downward pressure as to exaggerate the existing flexion into a complete occlusion.

(3) *Obstruction from Volvulus of the Transverse Colon; Catarrhal Appendicitis; Chole-Cystitis; Abdominal Section:*

J. W., age 50 years, operated for Dr. A. S. Mattson, of Moorestown, N. J., July, 1890. Absolute constipation had existed for nine days, but he was not seen by Dr. Mattson until the day before the operation. There was a history of attacks of ileo-cæcal pain, and this region was very sensitive about McBurney's test spot for the attachment of the vermiform appendix. There was general abdominal tenderness and distension, and considerable epigastric pain, as is usually found in all obstructions. On analyzing this, however, the pain and the tenderness were located, not in the epigastrium, but on either side, in the right and left hypochondria. The skin was jaundiced and the urine loaded with bile. All food was vomited, together with a suspicious smelling fluid at times. The prostration varied, and, while the heart's action was weak and rapid all the time, there came periods of collapse during which the patient seemed to be dying. When operated the pulse could not be made out at the wrist, and the heart beats were over 140 per minute. The usual treatment, carefully carried out, had failed to relieve the obstruction. I hesitated whether to make a lateral or median incision, as there seemed to be a strong probability of the trouble arising in the region of the appendix. The tenderness in the hypochondria excited enough doubt to lead me to choose the latter. On opening the abdomen and turning aside the distended loops of small intestine, the appendix came into view, "erect" and pointing upward and to the left, without adhesious, but distended and its walls evidently thickened by inflammatory processes of considerable duration. The distended colon was followed up to the hepatic flexure, where a large cystic gall-bladder was found. This had been disguised by the meteorism. The intestine was still dilated and continued so almost to the splenic flexure, where a complete twist of a short loop of the

transverse colon proved to be the cause of the obstruction. Below this the gut was collapsed. This was readily undone and the abdomen closed as usual. The condition of the patient did not seem to warrant meddling with the appendix or gall-bladder; in fact, all the manipulations were carried out with the greatest difficulty, as the anæsthetizer had been obliged to let up on the ether and resort to frequent hypodermic stimulation. The abdominal walls were, in consequence, very disagreeably tense. The patient for a time rallied well, passed flatus quite freely and had an enormous stool within an hour after the operation, but the heart failure recurred quite frequently during the night, and he died the next day. The autopsy revealed a catarrhal appendicitis, with thickening; a gall-bladder containing about a pint of muco-pus and about forty gall-stones, one of which had lodged in the cystic duct; the obstruction was completely overcome.

It is not often one meets with such a combination of "excuses" for abdominal section: a gall-bladder to drain, an appendix to excise and, the urgent cause, a volvulus of the colon!

In this connection I would record a case belonging to what I have classed as "miscellaneous" abdominal sections (those done for suppurative processes about the uterus or cæcum, exploratory incisions, etc.). It is one out of the usual run of appendical abscesses or excisions, to which subject I intend to refer more fully in a future paper.

(4) *Perforative Appendicitis; Abscess covered by Intestine; Laparotomy:*

R. W., age 12 years, operated for Dr. C. R. Norton of this city, August, 1890, on at least the twelfth day of an attack of appendicitis. Dr. Norton, it should be stated, had first seen him on the preceding day. The symptoms were the usual ones: ileo-cæcal tenderness; drawing up of the right lower extremity with numbness and then pain running down the thigh; a large tumor above McBurney's line, in creasing upwards; bowel resonance over this, and an indistinct sense of deep fluctuation; high temperature ( $102\frac{1}{2}^{\circ}$ ); rapid pulse (120), chills, etc. A vertical incision was made over the centre of the tumor through which the colon presented. The appendix ran up along the inner side of the cæcum, was much distended, and buried itself in a mass of protective adhesions, which shut off the abscess, behind and to the inner side of the large bowel, from the general abdominal cavity. The colon was allowed to bulge into the wound, which was left open, except at its upper and lower angles, and gauze packed in so as to protect the abdominal cavity in case of rupture and produce

adhesions that would later accomplish the same purpose. A channel was thus kept open, alongside the bowel, down to the abscess. On the eighth day a diarrhoea set in, consisting of blood and pus, and, in one stool, the characteristic faecal concretion found in these appendicular abscesses. The temperature has come down gradually; the pulse improved at once; the stools have resumed their natural character; the wound has healed by granulation and the boy promises to make a good recovery.

Here was a perityphlitic abscess over which intestine was made out, differing therein from those cases where the pus has more or less completely worked its way through the abdominal wall. With this outlet cut off it could find a vent, as in cases I have seen, either into the abdominal cavity, into the bowel, or into the loose connective tissue of the iliac fossa and push upward as far even as the thoracic cavity. Abdominal section insured an accurate diagnosis, permitted artificial evacuation of the abscess, if indicated, or, if the wound were left open, made this the point of least resistance, and thus favored a natural evacuation in this direction. It has been advised by some that, under the conditions found in this case, the abscess should be opened, cleaned out and drained. Feeling the intact intestinal coils on the one hand and Nature's protective adhesions on the other, it seemed to me to be tempting Providence to open up a stinking collection of pus in such a neighborhood. Instead, gauze was packed in to shut off the abdominal cavity and produce adhesions, and the abscess and the bowel allowed to bulge in this direction of the least resistance artificially produced. This naturally favored an evacuation externally, and, failing in this, for the same reason, an opening into the intestine. While the latter is not as desirable as would have been the former, it is infinitely preferable to rupture into the peritoneal cavity or into the connective tissue behind the colon. I am inclined to think that the pus would have found vent into the latter if left alone.

While not strictly belonging to abdominal surgery, the subject of hernia certainly comes within the sphere of intestinal surgery which has been referred to in this paper. Of nine herniotomies done during the past year, one case should, I think, be reported, as a supplement at least, to a communication presented by me to this Society a year ago.

*Strangulated Right Oblique Inguinal Hernia; Resection of Gangrenous Intestine; Union End to End by Rubber Rings:*

J. T., aged 65, operated for Dr. B. B. Gumpert, April, 1890.

Strangulation had existed for forty-eight hours in an old, partially-reducible hernia; faecal vomiting had supervened. The patient declined to go into the hospital, and the operation had to be done in a small, stuffy room, on a low, soft bed. Five inches of the intestine were found to be gangrenous and resected, with about four inches more to insure getting healthy tissue. The ends were united over rings of rubber drainage tubing, as described in the paper referred to. (HAHNEMANNIAN MONTHLY, October, 1889.) Interrupted, fine silk sutures were placed between the united strands of catgut from the rings and a catgut suture run over all and up and down the divided mesentery. Owing to the very unfavorable surroundings and consequent faulty asepsis, the gut was suspended in the abdomen by means of a strip of iodoform gauze passed through the mesentery. The opening was packed with gauze and a large absorptive dressing applied. The patient rallied well, passed wind and faeces subsequently, while the highest temperature was 100°. On the third day the gauze strip was removed and the wound repacked. Some local pain followed and then, gradually, complete constipation, with distension and vomiting. Turpentine enemata and glycerine injections were of no avail; purgatives were rejected and examination through the wound was negative. The rapidly supervening collapse precluded abdominal section, and the patient died on the fifth day. The autopsy revealed moderate adhesions about the hernial opening; no peritonitis elsewhere; great distension of the small intestine to three inches *below* the united ends, the point under which the strip of gauze had been passed, where an acute flexion was found. Below this the gut was collapsed. In spite of the tremendous strain on them from the distension, the united ends had held and were firmly adherent, with the rings in situ.

I report this case for two reasons:

1. In order to judge of a new procedure every case operated should be reported.
2. While the result was an unfavorable one, this method of uniting the divided ends of intestine was put to a most severe test, that of great intestinal distension, and stood it without giving way at any point.

There seems to be but little doubt that the flexion was produced on withdrawing the gauze, the sticky adhesions holding the intestine in its bent position. With better surroundings, age and general condition it would have been preferable to make a median in-



cision and suspend the intestine there, as is done by some German operators; with better surroundings, too, the gut could have been simply replaced and the hernial opening treated radically.

I should add that the case reported a year ago, in which twelve inches of intestine were resected and the ends united in the above manner, still continues to do well as regards bowel functions and general health. Some time since a small abscess formed in the cicatrix and a silk ligature (from the neck of the sac) was discharged. With this the hernia recurred, but is readily controlled by a truss. I naturally feel that with the experimental and clinical results obtained we are justified in giving this method a further trial.

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#### CLINICAL AND PATHOLOGICAL SIGNIFICANCE OF ALBUMINURIA.

BY W. C. GOODNO, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania.)

It is but a few decades since albuminuria was of doubtful meaning. But Richard Bright and his co-workers and successors demonstrated its dependence upon nephritis in some form with such clearness and conclusiveness that, from a symptom of doubtful or unknown meaning it has become the clinical corner-stone of that once obscure, but now well-defined, group so appropriately designated Bright's diseases, Bright's diseases being simply the various forms of nephritis, acute and chronic. The great importance of albuminuria as an indication of nephritis has led to exaggerated estimates of its constancy in this affection, as well as of its exact clinical significance. So firmly has the idea that albuminuria means Bright's disease become fixed in the professional mind, that the terms have become almost synonymous, many authors even using them interchangeably. In view of this, we cannot wonder that diagnoses of Bright's disease are still, in most instances, made with the test tube only, and that the majority of general practitioners diagnosticate negatively or affirmatively after this test alone has been applied.

Considerable light has been shed upon this subject of late by our renal specialists, but there is much to be made clear, as well as a necessity for an increased corroboration of the results obtained by

recent investigators. We know enough to-day, however, to say in no uncertain tones: Albuminuria does not mean Bright's disease and Bright's disease cannot be diagnosticated by albuminuria alone. Just what it does indicate it is the purpose of this paper to inquire into. I will relate the histories, briefly, of a few cases, which constitute the basis of some conclusions and hypotheses to be stated at the close.

CASE 1.—Gentleman. Officer in a large corporation, 36 years of age, has been under my care for some five years past. At that time, desiring to increase his life insurance in a certain company, he was required to submit to a urinary analysis. To his consternation their examiner reported "albumin and casts." His application was of course rejected. This brought him to me, his family physician. Scores, perhaps hundreds of analyses of his urine, by myself and others have been made since that time with the result of finding an almost constant albuminuria. Generally, the ring of albumin developed by the cold nitric acid test is about as thick as a nickel five-cent piece. Rarely, it has been absent for a day or two or during some portion of a day, especially in the morning. The quantity is increased by unusual exercise and certain articles of diet. At least fifty times (I speak thoughtfully) have we made careful search for casts, using various methods, with negative results. Except in one instance, when a long, slender transparent cylinder of the so-called mucous variety was discovered, a form sometimes found in the urine of the apparently healthy. I have sent the urine to experts with the request for a careful examination, but with the same result. Degenerate renal epithelia and other indications of kidney disintegration have not been discovered. The urine is clear, amber, normal in quantity and the average specific gravity, based upon a number of 24-hour collections, was about 1022. Few men are as free from symptoms of any character indicating ill health. During the past two years the amount of albumin has been decidedly less. Longer periods of remission have also been observed. Quantitative analyses, as well as the specific gravity showed the solids to be present in normal quantity. Cardio-vascular changes cannot be detected and the ocular fundus is normal. There is unusual freedom from lithæmia for a man of his character and habits.

CASE 2.—A large, apparently healthy lawyer, æt. 49, doing hard work in his profession, came under my observation about seven years ago. He represented to me at that time that he had had Bright's disease for several years, but seemed indifferent as to its seriousness. He was accustomed to the examination of his own urine, and stated that albumin was never absent, although the quantity was generally small. My own tests subsequently showed a constant albuminuria, i.e., daily, but occasionally absent from the morning urine. Sometimes after intense work, such as an exciting criminal case, the amount of albumin present during the latter hours of the day was quite large—

by the cold acid test the ring being the thickness of two five-cent nickel pieces. The specific gravity varied from 1018 to 1026; quantity fluctuating from 50 to 60 ounces; color often high. Repeated examinations failed to show tube-casts. Lithæmia was quite marked; ocular fundus was normal; the heart's action seemed rather strong, pulse rather hard, but hardly sufficiently so to warrant a diagnosis of cardio-vascular changes. There was some degree of gastric catarrh, but the patient's habits relating to his stomach were thoroughly bad, as were all of his habits. The patient had urethral stricture of large calibre, several points of contraction being discoverable. A No. 30 French sound could be passed. Decided gleet was absent, a simple glueing of the meatus occurring. There was no evidence of catarrh of any higher portion of the urinary tract. Such a source of the albuminuria could be positively thrown out, as it existed prior to the primary urethritis. This gentleman came to me for the treatment of his urethral condition, having been told nothing could be done for his Bright's; to live properly and prepare to meet his end. An albuminuria of at least ten years finds this patient enjoying quite good health, free from any other signs or symptoms of nephritis.

CASE 3.—A man, æt. 40, a conductor upon a horse-car line, called upon me several years since (1885), complaining of some loss of flesh, debility, pain in the back, etc. An examination of the urine demonstrated albuminuria, a well marked ring forming upon the cold nitric acid. Repeated examinations showed the quantity to be exceedingly variable and entirely absent, at times for several days. Careful observation upon the part of the patient developed the apparent dependence of the albuminuria upon the ingestion of albuminous food, quantities of nuts, or highly-seasoned food; and also, in some degree, from exercise. No other evidence of Bright's disease could be secured. Correction of diet, and regular, light exercise diminished, but did not remove permanently, the albumin from his urine. Disappearance of a catarrhal dyspepsia, due especially to more careful selection of food and the hours of partaking of it, seemed to be the reason of the relief of the general symptoms complained of.

CASE 4.—A young lady, æt. 22, has enjoyed good health. Had scarlatina at 10 or 12 years of age, and typhoid fever at 17. Seemed to recover her health, however, after each disease in a normal period of time. Complaining of backache, her urine was examined, in pursuance of a general principle, rather than with the expectation of finding renal disease. The examination revealed a trace of albumin. The color, percentage of solids, and specific gravity were all normal. Leucorrhœa was not acknowledged. Nor was there catarrh of any of the mucous membranes. The vascular supply to the cutaneous and mucous surfaces is large, her color is high, and there is a disposition to bleed from small wounds. The albuminuria was distinctly intermittent, it being absent for days at a time, then present at every test for a longer period. The color was rather high, specific gravity 1022

to 1028; quantity rather scant; several unsuccessful searches for casts were made. Constipation has been a very troublesome symptom. There was little change in the urinary condition during some eighteen months this lady was under my observation. I have not heard of her for two years past, until during the preparation of this paper. She states, in a letter from another city, that albumin was discovered by her medical attendant through a period of several months after passing from my care; but feeling well, she has paid no further attention to the subject during the past year.

CASE 5.—A gentleman, 63 years of age, came under my care some five years since complaining of retention of urine. Examination revealed an enlarged prostate gland. The retention had just occurred, but had been preceded for some time with more or less difficulty in urinating. An occasional use of the catheter, with antiseptic precautions, relieved him much, but in spite of this relief his general health failed, flesh, appetite and strength diminished. The stomach was irritable, the tongue coated, then irritable, red, raw, cracked. Nausea troubled for a time, then vomiting. Cardio-vascular changes were apparently somewhat developed. The urine when first examined was 1015, 60 oz., no albumin. Subsequent examinations were more carefully made, when the stomach and other symptoms could not be accounted for upon any other hypothesis. Through a period of several months examinations were frequently made, the specific gravity averaging from 1015 to 1005, the quantity sometimes being as high as five pints. Degenerated epithelia and casts, entirely fatty and hyaline. Finally uræmic manifestations closed the scene. A post-mortem examination was obtained, and cirrhotic kidneys discovered. At no time could albumin be detected in the urine. The clinical picture of cirrhotic nephritis during the latter stages was perfect.

CASE 6.—G. H., æt. 46. Complaining of some general indefinite symptoms led to my examining his urine. There was a well-marked albuminuria. Continued examinations demonstrated it to be intermittent, the period of its existence being perhaps two-thirds of the time. Upon one occasion, out of very many examinations, a narrow cast without adventitious contents was discovered. The genito-urinary passages were normal. After about two years the individual succumbed to an attack of cerebral hæmorrhage. I was so fortunate as to make an autopsy. The hæmorrhage was from a well-marked sacculated pouch upon one of the branches of the left middle cerebral artery. The arteries were in general quite healthy. The kidneys were apparently normal in size, but the left one quite movable; capsules not thickened or adherent. In texture they seemed somewhat softened. The microscope showed light-walled, rather large vessels, indeed, with apparently large blood supply, the general framework of the organs seemed defective. Here and there there was slight intertubal hyperplasia. The tubular elements were rather large, and did not stain very well; had too much of a granular appearance, and the structural peculiarities of the renal epithelium

did not come out well. There were no coagula within the tubes. It will be observed that the general indications are all in the direction of defective kidney development, from the loose attachment up to the large weak tubular epithelia, the latter having in slight degree the appearance and conditions found in acute nephritis, viz., slightly granular, indistinct structure, the seemingly large elements and increased blood supply. Observation of the kidneys of several persons dying from various diseases, during the course of which albumin occurred, have presented much the same appearances, but not the evidences of defective development.

CASE 7.—I had the opportunity of examining, several years since, the kidneys of a man who had been under the care of a colleague for some time suffering from intermitting albuminuria. Evidences of Bright's disease of any other character had not been discovered. He was 43 years of age at death, and had been the subject of slight albuminuria for three years, so far as known. The kidneys seemed normal in their external conditions, but were rather soft. Their cut surfaces revealed nothing special. The left contained numerous calculi, all small and of the uric acid variety. The right only two small "gritty points." Upon enlargement the tubular epithelia were found slightly granular, here and there somewhat cloudy. Neither of these changes were pronounced, however. Looking over a large number of fields, indeed, sections, I discovered two casts in situ. Both were of clean, coagulable material and free from degenerate epithelium. While the epithelia impressed me as swollen, they were not sufficiently so to encroach upon the lumen of the tubes decidedly. Intertubular hyperplasia was clear at some points. If there was any change in the blood supply it was diminished. The patient had suffered somewhat from rheumatism and frequently had sandy deposits in the urine.

Of cases of Bright's disease without albuminuria, at least during quite continued periods of observation or with an intermitted albuminuria, I could increase the number largely, but I have given sufficient to illustrate the point I would impress, i.e., that Bright's disease does not always nor constantly, in a given case, present an albuminuria. From a study of the related cases and others in my own collection, as well as of the observations of others, I am impressed with several things:

*First.* Albuminuria must not be looked upon as necessary to the diagnosis of Bright's disease.

*Second.* Albuminuria often exists independently of any clinical or pathological evidence of nephritis or any condition of the genito-urinary tract which can account for it.

*Third.* Albuminuria, independent of Bright's disease, is sometimes associated with evidences of defective development of the

kidneys, or rather an imperfect structural condition, which may, perhaps, be, in the main, acquired.

*Fourth.* The direction of the tubular and other changes is inflammatory.

*Fifth.* The absence in a majority of these cases of well-marked diathetic states, as lithæmia.

Hypotheses are valuable, as indicating lines of thought and work. I would propound: Does not the kidney, independently of recognized disease, vary in its structural integrity in different people?

As in some the cutaneous epithelia are imperfectly developed and an imperfect skin is the consequence, so in the kidney. Are not the epithelial glandular cells brought into existence with impaired nutritive activity, resulting in abnormal function-action? They stand guard but poorly and allow the most precious of the nutritive fluids to pass unchallenged. Do not the changes discovered in such kidneys suggest that all that is necessary to the development of Bright's disease is the application of the exciting causes of the inflammatory state?

May not the condition of the blood be closely related to persistent, so-called, physiological albuminuria?

While these few observations are of but little value in the forming of conclusions respecting the pathology of so interesting and important a condition, yet "every little helps," and I trust the results arrived at in these cases may lead to more careful study of similar ones.

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#### SCIENCE APPLIED TO THERAPEUTIC OCCULTISM.

BY J. P. DAKE, A.M., M.D., NASHVILLE, TENN.

THE presidential address of Prof. J. D. Buck, at the late meeting of the American Institute, at Waukesha, is calculated to draw attention to those influences which are not now recognized as acting under any known law, or in accordance with any well defined principles, and which, nevertheless, must be credited with some curative power. Dr. Buck, in the address referred to, advances as far as the conservative position he holds at the head of a regularly organized and active medical college, will allow, in mentioning agencies or influences that may not be weighed or measured by the ordinary tests of the pharmacy and dispensary, and in asking for them a consideration

and scrutiny that shall determine their character and uses if not, also, the philosophy of their action. Having listened to the address during its delivery and having carefully read it since its appearance in print, I must accord to the learned lecturer a perception and a courage not often seen in scholars and teachers of his rank. His plea is not for a wholesale acceptance of what seems to the learned world as very mysterious, if not also visionary and worthless. He asks for no abandonment of means generally employed under recognized principles and rules in the treatment of the sick, but for an extension of scientific methods to agencies or influences now, and in all past time, regarded as too sacred or too devilish, too imaginary or too foolish for any serious consideration.

He would maintain the applicability of the homœopathic principle and its direction as a rule, in the employment of all such agencies in the practice of the healing art. So far as it may be possible to trace and note the pathogenetic effects of such agencies in the human system, I am prepared to go with Dr. Buck in advocating *similia*.

He has truly observed that this power, variously designated as animal magnetism, mesmerism, hypnotism, mental suggestion, faith, has been employed empirically and not in accordance with any recognized principle in therapeutics. In the absence of a definite pathogenesis, such must ever be the case in recording disturbances of human health by its exercise.

The homœopathic principle is clear, definite and well-settled as referring to ailments to be removed on the one hand, by means that on the other, have shown a power to produce similar ailments in well people. Where such a relationship does not exist, or cannot be recognized, it would be idle to talk or dream of homœopathy.

Of this proposition I am fully convinced, however, that any power sufficient to cure must also be sufficient to make sick, it being understood, of course, that the power in the one case, must greatly exceed the same in the other, especially where the homœopathic relationship exists, indicating greatly increased susceptibility.

I am in accord with Dr. Buck when he regards disease as a disturbance of the vital "equilibrium," or its loss, and the cure as its restoration or regulation.

The practical question, suggested by the data and reasonings of his lecture, seems to me to be this—whether scientific investigation should be directed to the ascertainment of the pathogenetic effects of the now illy-defined and mysterious agencies referred to, so as to

apply the homœopathic rule; or, rather to the acquisition of a knowledge of the alleged cures by them and the application of logic, so as to arrive at some other principles or rules to guide us in their employment?

Dr Buck objects to empiricism, and advocates law; and he is right.

But some fearless and rigid examinations must be pushed, to determine whether such agencies are to be classed with the articles of hygiene or of medicine, with *pabula* to be increased or diminished, or with *excoitantia*, to definitely influence functional activity and harmony.

The older writers on *materia medica*, especially that classical author, Pereira, observed distinctions and recognized classes not often mentioned in later years. He wrote of the *impoderabilia*, and of *psychical remedies*, etc.

Except with Hahnemann and his followers there seems to have been a relegation of the imponderable and the psychical to the realms of quackery, till since the advent of Charcot and a few other scientific investigators.

As I said, it should, first of all, be determined from well ascertained facts whether the pass, the touch, the look, the word or the will of one person upon another, is pathogenic definitely and so uniformly as to come under the homœopathic law; or whether it must rank with hygienic supplies and be directed by hygienic rules.

I fully agree with Dr. Buck, that it is high time the medical profession should earnestly inquire into the alleged cures by hypnotic or psychical influence, by mental suggestion and methods known as "Christian science," "faith-cure," and the like. Too many sensible and educated people are telling of cures effected by such means for the matter to be turned aside with an incredulous smile or contemptuous shake of the head.

All along through history we read of miraculous cures effected by occult agencies, miraculous, because not understood; and every physician, of any considerable experience, has met with recoveries for which he has been totally unable to account, and witnessed the working of agencies in the sick-room and undoubted results, entirely beyond his philosophy.

Hahnemann taught the world the uselessness and harmfulness of heavy drugging and of venesection and other old-time heroic measures. He fought against gross materialism, and secured the reign of the milder powers.



To him the whole profession is, to-day, indebted for the single remedy and the smaller doses, as well as for the homœopathic uses of scores of medicines.

Imitating him, let us not be afraid to look squarely in the face of all who claim to cure without medicine; and let us not shun the opportunity to ascertain the correctness of the claim on every possible occasion.

I have long ago said, that if healing power can surely come to the sick by the touch, the word or the look of a "healer," I have no fault to find, and am ready to abandon every drug and every cumbersome measure to which I am now wont to have resort.

What I wish to know is that the alleged cures are *bona fide*; not imaginary nor fictitious. And I ask for no stronger proofs than those I claim for cures effected by ordinary means, except where the potential property or positive power of the agency exercised or employed is of very doubtful reality.

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### THE SEQUENCE OF SYMPTOMS.

BY O. EDWARD JANNEY, M.D., BALTIMORE, MD.

No one can doubt the value of a knowledge of the order in which symptoms appear in the course of a drug-proving, together with the peculiar conditions which accompany them, and it would appear that with such knowledge a closer similarity between a disease and a drug pathogenesis may be perceived. It would follow also, in accordance with the law of similars, that with the possession of such knowledge, more certainty would be felt in prescribing, and furthermore, diseased conditions could be relieved by means of drugs, with greater success than at present.

In an attempt to study the order in which symptoms appear and their concomitance, using the *materia medica* we now have access to, as a means, it is found at once that it is a much easier task to ascertain and note the concomitance, or the conditions under which symptoms may appear and the peculiarities surrounding their appearance—forming, in large degree, "characteristics"—than it is to discover the *order* of their appearance.

To discover the concomitance of symptoms, careful study of original provings, such as compose the *Cyclopædia of Drug Pathogenesis* answers well and may appear well defined, even in the Hahnemannian schema. When an attempt is made, however, to

ascertain the order in which symptoms occur in the course of a proving, certain difficulties will be at once met with.

In the first place provings have not been carried on with a view of ascertaining the sequence of symptoms and their records; even the originals are extremely misleading. Many of the provers have used preparations of drugs that cannot be relied upon to produce accurate results; many have been inaccurate in recording symptoms as to their time of occurrence and similar valuable points. Even those provings which bear evidence of having been carefully conducted are of less assistance in the present inquiry than would be imagined without investigation.

Nearly all provers are recorded as having taken a dose of the drug at least once a day and many of them, several times a day. In such cases, a little thought will show how difficult it is, when any new symptom appears in the course of a proving, to ascertain whether it was caused by the dose taken to-day, yesterday or earlier yet, and where its place is in relation to other symptoms.

To illustrate this point, Proving No. 21, of chromium, *Cyclopædia of Drug Pathogenesis*, will be utilized, the proving having been conducted by Dr. Norton with evident care. The amount taken was one grain of the first trituration of kali bichrom. daily. On the fifth day of the proving occurs the following symptom :

“Frequent acid risings; acid burning in stomach once or twice in day. During afternoon taste like salt in the mouth. Transient acute pain at base of l. scapula; frontal and occipital headache; earache in evening.”

These symptoms were recorded on the fifth day of the proving, but is it possible to ascertain whether they were produced by the first, second, third, fourth or fifth dose? Perhaps some from the dose taken on one day and some from doses taken on other days of the series. This is further complicated by the fact that “frontal and occipital headache” had occurred also on a previous day. On this fifth day, therefore, was it caused by the dose taken that day or a previous one? These difficulties seem to make accurate work on this line impossible.

It happens that Dr. Norton made three provings on himself with kali bichromicum. An opportunity is here presented to ascertain whether a drug will, under similar circumstances, in the same individual, invariably produce symptoms in the same order and at the same distance of time from the moment of taking the drug.

For if there be an invariable sequence of symptoms, the same day of each proving should exhibit identical symptoms. Examine now the record of the twelfth day of each of Dr. Norton's provings:

*First Proving:* "Rheumatic pain in knee and chest."

*Second Proving:* "Woke with all feelings of having caught severe cold. Nose full and loaded as if going to discharge abundantly; throat dry, with pain on swallowing; tongue thickly furred and of light brown color on dorsum; soreness in larynx; pain in sides and nape of neck and in l. shoulder; throat looks red and inflamed around tonsils; cough began on awaking; sputa free and thick, transparent, of slaty color."

*Third Proving:* "After breakfast uneasiness in stomach lasting all day, as if from over-eating, seated two or three inches below ensiform cartilage."

It will be seen that in this instance at least no similarity exists between the groups of symptoms brought out on the same day of each proving; on each occasion a different part of the body seemed to feel the influence of the drug. On looking over the records of the entire proving, the symptoms of one day only of the fourteen days that each proving lasted—the fifth day—exhibit resemblance.

*First Proving:* "Frequent acid risings; acid burning in stomach once or twice in day. During afternoon taste like salt in mouth. Transient acute pain at base of l. scapula; frontal and occipital headache; earache in e."

*Second Proving:* "Same (rheumatic pain) in nearly all joints; sensation as of a hair at the back of tongue and on velum, lasting a considerable time, and not removed by eating or drinking."

*Third Proving:* "Salt taste in afternoon; sour risings and burning in stomach; rheumatic pains in nearly all joints."

"Rheumatic pains" are noted throughout the provings and are not peculiar to the fifth day.

Again, it would be expected that when a "characteristic" symptom appears it would be brought out on the same day of each proving made by the same person under similar circumstances. In Dr. Norton's provings a peculiar symptom that appears in each of the three records: "Sensation as of a hair on the back of tongue and on velum, not removed by eating or drinking," occurred on the fourteenth day of the first proving, the fifth day of the second, and the thirteenth day of the third.

In many provings what little regularity is observed in the dose taken is broken by allowing one day or more to intervene without taking any of the drug.

It would appear, then, taking the records of the provings of all drugs as they are to be found, that they do not furnish data sufficiently accurate for scientific work in ascertaining the sequence of symptoms, and no one who has investigated the subject could have confidence in results based upon these records so far as they bear on this point.

The only approach apparently to anything like accuracy would be to re-prove each drug with special reference to the sequence of symptoms, giving but a single dose of the drug and recording its effects in the order of their occurrence.

And were this to be done there yet stands in the way of accuracy the fact noted above, that symptoms do not appear in the same order always even when the circumstances are similar. Personal peculiarities, the state of the system at the time of proving, local effects of the drug, the size of the dose, and many other circumstances interfere with the regularity of the sequence.

Nor does it seem probable that any but crude and uncertain results can be obtained by the study of cases of poisoning, since even the most virulent poisons do not affect all persons alike. Witness arsenic, which in one person may attack the stomach and bowels primarily and in another person not these organs at all, apparently, but the nervous system alone.

If, then, sequence of symptoms is an uncertain guide in the present state of knowledge, upon what must reliance be placed in prescribing for disease? The answer would seem to be the same now as in the days of Father Hahnemann, the *totality of the symptoms* at any given stage of the disease. We are able with the knowledge we have to form a good, and in numerous cases a very complete, picture of the effects of many drugs on the system, and thus have the means at hand to relieve disease.

While our records of provings do not seem to furnish data by which to ascertain sequence of symptoms, yet they are a mine of wealth to him whose aim is to ascertain the true pathogenesis of each drug. The search-light of scientific inquiry is being thrown upon these records in the effort to ascribe to each remedy those symptoms and those only which it produces on the human system.

When this new material, accurate and reliable, shall be accessible to every prescriber, he must feel a confidence in a materia medica in which there is a reasonable certainty that every symptom therein recorded is a true effect of the drug, and with such reliable aid the physician will be enabled to perform his work of mercy with increased confidence and success.

## A CASE OF EPICYSTOTOMY FOR STONE, AFTER THE METHOD OF DITTEL.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

(Read before the Philadelphia County Medical Society, June, 1890.)

THE following case presents one or two points of rather unusual interest, together with a comparatively new operative procedure. Therefore, I hope to be pardoned for asking your attention for a short time to its description.

Mr. C. S., æt. 69 years, was sent me, through the courtesy of Dr. A. M. Barnes, for examination, having suffered more or less constantly for the past few years with symptoms pointing to some vesical trouble, and which of late had become so severe as to be at times almost unbearable. The patient having been a hard-working man all his life, was rather debilitated and did not carry his age very well. At the time of his first visit he complained of frequent micturition, accompanied by pain, especially at the glans penis; at the end of the act the pain was entirely located in the bladder. The urine was ammoniacal, containing large quantities of mucus and pus, occasionally blood and a slight amount of albumin, but not any more of the latter than could be accounted for by the pus. There were no casts or anything leading one to suspect that kidney changes were present. Physical examination revealed a large penis, slight urethritis showing itself by the presence of a discharge. Testicles normal. Rectal examination showed a slight enlargement of the prostate. The introduction of a catheter proved the bladder to be incapable of emptying itself completely, as over an ounce of residual urine was withdrawn. On sounding, a slightly eccentric hypertrophied bladder markedly trabeculated was found, together with a small stone, first felt in the fossa on the right side, the most usual place, especially in old men.\*

Further examination showed a small tumor a little posterior to the left lobe of the prostate, which felt exceedingly hard, leading me to suspect an encysted stone, which later on proved to be the case. Operation was advised; to this the patient readily consented. After careful consideration the high operation was decided upon, as

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\* Ultzman. Eight times out of ten.

lithotrity, to my mind, was excluded by the severe and long-standing catarrh, not considering the difficulties the prostate, although but slightly enlarged, would offer.

The median section was excluded on account of suspicion of an encysted calculus, which, if not impossible, would have proven exceedingly difficult to remove by that procedure.

I therefore opened the bladder above the pubis in the following manner :

The patient having been brought under the influence of ether, the pubis was shaven and thoroughly cleansed in the usual way ; the bladder was carefully washed with Thiersch's solution, after which the pelvis was raised, as first suggested by Trendelenburg, this causing the abdominal contents to gravitate toward the diaphragm, and in so doing, draw the peritonæum with them. The abdominal wall was now incised in the usual manner until the bladder wall was exposed. After being satisfied that the peritonæum was out of harm's way, the abdominal incision was enlarged upward with a probe-pointed bistoury. A staff was now introduced and the beak drawn against the pubis. After having placed the thumb on the point of the instrument, it was gent'y pushed back, making the bladder wall tense. The handle of the staff was next entrusted to an assistant and the bladder incised. A hook was then placed in the upper angle of the wound, holding the bladder up. A finger was now introduced, and by means of a pair of forceps six small uric acid calculi were removed. On further examination the seventh stone was found encysted at the site suspected. On the right side, corresponding with the normal depression, a diverticulum was found, the bottom of which could barely be touched by the finger. The middle lobe of the prostate was slightly enlarged, but not sufficiently so to justify its removal, nor would it have been advisable in the condition of the patient. The bladder was now thoroughly irrigated and a Trendelenburg drain with a Dittel modification introduced, also a catheter *a demeure*.

The object in carrying out the above *technique* was to avoid the possibilities of a rupture of the bladder, which I have had the misfortune to see on more than one occasion, and just in such cases as this where the sub-mucous and possibly the deeper layers of the bladder were infiltrated as a result of the chronic cystitis. It also took much less time, a factor of no little importance where the patient's vitality is low. This method, so far as I am aware, was first introduced and practiced by von Dittel, of Vienna.

The after-course was not altogether uneventful, and therefore a few notes from the record may prove of interest.

As the patient was exceedingly restless and suffering considerable pain after the reaction from the ether, a suppository containing one grain of opium and one-quarter of a grain of extract of belladonna was given. This was repeated in the first-twenty four hours, at the end of which time there developed a slight meteorismus which gradually increased for the forty-eight hours following, giving rise to considerable pain and discomfort to the patient and no little anxiety to me, especially when vomiting set in. Peritonitis was naturally thought of, yet I was morally certain the peritonæum was not wounded during the operation; the temperature was also not in ratio to the rest of the symptoms. At no time did it reach over 100° F. His pulse, furthermore, had none of the characteristics of peritoneal inflammation, nor did his general condition indicate such. The bowels had not been moved since before the operation, so a turpentine enema was advised. This was followed by the escape of considerable flatus. I was rather at a loss to account for his condition until Dr. Barnes suggested that it was due to a paralysis of the bowels caused by the opium, he having seen such cases on several occasions. The subsequent course, which was uneventful, rather proved such to have been the case, as after the free escape of flatus and a few small passages the tympanites immediately disappeared. The bladder was washed with Thiersch's solution every five hours for the first three days, after which twice daily. The cystitis rapidly subsided. The catheter was removed at the end of the first twenty-four hours, the drain on the fourth day, after which the wound rapidly healed. Since the operation the patient is enjoying comparatively good health.

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## PNEUMONIC GRIPPE, OR PNEUMONIC INFLUENZA.

BY WALTER RALEIGH AMESBURY, M.D., NICHOLASVILLE, KY.

As there exists a more or less intimate relation between the pneumonic symptoms of la grippe and lobar pneumonia, and being somewhat puzzled as to how I should designate the symptoms of the former from the latter, I have, for the want of a better nomenclature, taken it upon myself to give the combination the name of pneumonic grippe,

and in this letter to describe it by that name. The context will give my reasons for that name.

At the time of the epidemic of la grippe or influenza in the early months of the present year, I had the good fortune of treating 366 acute cases, and 43 cases (chronic) which had been prescribed for by others or were self-medicated with antipyrine, quinine, calomel, teas of different kinds, and whiskey, etc. These latter patients came to my office during the period of 6 to 10 weeks after the subsidence of the acute symptoms of the disease and each suffering in different ways and in various degrees, all of whom were quickly relieved of their several affections by the indicated remedy.

The symptoms in my locality within the first 24 hours would be some cough, with white, frothy expectoration, more or less puffed eyelids, and puffiness of the whole face, slight watery discharge from nose, with a stopping up of that organ, great general lassitude, inclination to stretch the limbs to their fullest extent, lumbar backache, as if the back would break in two, aching in every limb as if bruised after being pounded, general soreness of all the muscles, intense throbbing headache and exquisite pain at the root of the nose, photophobia, cannot bear noise, headache worse on movement, impatient, irritable mood, in some cases vomiting of a yellow and gluey frothy mucus, great thirst, great restlessness, loss of appetite, tongue coated and furred of yellowish white color, with clear edges, congested face, constipation; pulse was hard, full and tense, the number of beats varying with the temperature, the temperature ranging generally from  $98\frac{1}{2}^{\circ}$  F. to  $103\frac{1}{2}^{\circ}$  F.; several cases registered  $104^{\circ}$  F.; in three cases,  $105\frac{1}{4}^{\circ}$  F. In 13 cases the symptoms as given were present in every item, the same clinical thermometer being used, and in every one of these cases it registered  $98\frac{1}{2}^{\circ}$  F. I would not be surprised at this had I taken the temperature under the arm, as then there would be room for doubt, but in every adult the temperature was taken under the tongue, except in the case of children, when it was taken under the arm. I could not believe my thermometer when the symptoms were so marked, so gave more time, but with no higher registration; and while I am on the subject of temperatures I mention the fact that I prescribed in all these cases just as I had done to the high temperatures, with acon. 1x, and bell. 1x in alternation, and out of curiosity and research I returned to five of the 13 cases at times varying from one to three hours after giving the remedies, and in each of these cases the thermometer indicated from  $102^{\circ}$  to  $103\frac{1}{4}^{\circ}$  F. Somehow the drugs unbridled the pent up temperature.



I wish now I had tried the temperatures in the whole 13 cases, but I contented myself with the five, as I was visiting from 35 to 42 cases daily, and had no time to make double visits (I would feel obliged if some reasonable explanation could be given to me by one of our school in these cases, putting aside the liability of error in taking the temperature, for I took every precaution not to be deluded myself). The symptoms in the next 24 hours, *i.e.*, 48 hours from the beginning of the symptoms without medical aid being called in had, in addition to the foregoing symptoms, slight circumscribed to diffuse bronchial râles, abdominal pains in some, but more often pains in the lungs themselves, or a neuralgia along the intercostals; some had a loose cough, but more often a dry, irritating cough, with a frothy, or white or grayish-white, and in some grayish-yellow and lumpy expectoration of varying quantities. By auscultation very slight crepitant râles, not always discernible in all cases at this period, but I found that in almost every unmedicated case, *i.e.*, on the expectant plan adopted by the patients themselves, there existed, after 48 hours to the 70th hour, plainly pronounced sub-crepitant and crepitant râles, with more neuralgic pains along the intercostal nerves, generally on the right side, from the fifth to the seventh rib inclusive. Some patients complained of burning and pricking in the lungs, and this was generally seated also in the right lung, and at this period the expectoration was still frothy or lumpy gray or lumpy yellowish color, but more abundant.

On studying these acute cases from every stage of the disease, I could not help coming to the conclusion that the pneumonic symptoms after the 48th or 70th hour from the development of the disease, is *not* a complication of la grippe, but that the pneumonic symptoms are present from the very commencement and are part and parcel of the disease called la grippe or influenza, only that in the first hours of the disease we are not able to hear the fine sounds in the lungs, nor upon inquiry could I find, in a single case, the prolonged chill or rigor which is diagnostic of true lobar pneumonia. I had five cases where the patients treated themselves for a varying number of days with simple teas; in two of these five cases I saw one after eight days, the other on the eleventh day; on auscultation, percussion, history of case, the temperature and sputum made my diagnosis positive of being pneumonia following on grippe; the symptoms, except dulness, were well pronounced in every particular, and that the patients did not appear so ill and the symptoms not so severe as seen in a case of true pneumonia. There are other points

of interest between the pneumonic symptoms of la Grippe and true lobar pneumonia, which to me make a very decided differential diagnosis. In all these cases of pneumonic symptoms implanted upon grippe I have not found a single case in which there was the characteristic prolonged rigor which a typical lobar pneumonia has. The pneumonic grippe has a succession of short-lasting chills, and there may be only one or two slight ones; more especially are these chills heard from in the first 24 hours. Then the signs of inflammation in the lungs and intercostal neuralgia of the pneumonic grippe was not in any case so severe as in the typical lobar pneumonia, though the pains are somewhat identical, but in intensity they are much more reduced. Again, in the pneumonic grippe, at the 48th to 70th hour the crepitant râles are more easily to be found, and more so in some cases than others. Sometimes I found one, two or three circumscribed spots varying in size, at others the crepitation was general, but in the separation of the walls of the air-cells on inspiration, which produces the crepitant sounds to a typical degree in true pneumonia, is a good deal more modified in the crepitation of pneumonic grippe, which gave me the impression as if water had been added to the mucilage between the student's hands while producing the experimental sounds of the crepitant râles of the lungs heard in disease. Another singular fact about the crepitant sounds of pneumonic grippe is, that the sounds are rapidly shifting from one place to another; one morning I would find it in one or two localities, and by the next morning the crepitant sounds would be found in some other place. Theorizing on the presumably ambulatory character of this crepitation, I think that it must be that the previous crepitation sound perfectly disappeared from 12 to 30 hours by absorption and resolution, as the inflammatory character was not severe enough to keep the process up for a longer time, or to spread it over a greater surface of the lungs, and that new circumscribed spots of crepitation made their appearance; in some cases a day or two would elapse without any sign of crepitation, either to return in the same manner or to disappear suddenly not to return again, these characteristics diffused in proportion to the severity of individual cases. In only one case, and that in one of the five on the eleventh day, could I find dulness on percussion, and that with difficulty, over a small circumscribed area on the right side. In only the eleventh-day case did I see something resembling the rusty sputum of true pneumonia; it is somewhat like it, but is less in quantity and of a redder color in quality than the true rusty sputum

of pneumonia. As regards the other severe and distressing symptoms of lobar pneumonia, they have not been seen by me in any of the above number of pneumonic grippe cases.

Before giving a résumé of treatment I must add, that out of the 409 cases treated by me, about 400 were of the colored race, living, nay, existing, in hovels, with hardly any shelter, no adequate food or clothing, and no enviable hygienic surroundings; everything about those people looked as if success in curing them was against the physician and his efforts, but not so, as you will see. "Homœopathy won't down," put her system where you will; use her right, she won't fail.

*Complications of "La Grippe" Noticed in the Acute and Chronic Cases.*—1. Out of 7 cases of utero-gestation at different periods of development under my supervision, there was one case of premature labor at 8th month in a delicate woman suffering from chronic gastric catarrh. Labor began about 8 hours from commencement of grippe and terminated in about two hours. Temperature at first  $103\frac{1}{2}^{\circ}$  F., at termination of labor,  $102\frac{1}{4}^{\circ}$ . Next morning,  $98\frac{1}{2}^{\circ}$  F. Under acon. x, bell. x, āā, gtts., xx, in  $\frac{1}{2}$  g. H<sub>2</sub>O, teaspoonful every half hour in alternation, mother recovered. Infant died in 6 weeks. Causes unknown, as medical aid was not called in.

2. One case has 4 healthy children, 8 to  $8\frac{1}{2}$  months pregnant, attacked by grippe. Temperature,  $102\frac{1}{4}^{\circ}$  F. Had many different symptoms in the course of the first 12 hours, among them slight convulsive fits, pains in back and up the spine to medulla. In 3 days she was comparatively well. At night of 3d day she had another convulsive fit at 2.30 A.M. Labor was completed. Everything went well for first 3 days when infantile tetanus set in, which terminated in the death of the infant on the 9th day after birth. Mother's urine was normal by chemical examination; and no signs of albuminuria physically.

3. Man, æt. 76, had grippe; he poured in whiskey without effect; after 15 days of self-treatment by whiskey was attacked by erysipelas of face; about 5th day the face was almost well, when by the ambulatory character of the affection, it seated itself from halfway up the biceps to middle of left forearm; the course was so rapid and destructive here, being of a genuine phlegmonous type, that everything was against the old man. The 8th night being a wet one, the affection again seated itself about the left face and eye, and by the next morning he was stone blind in that eye; meanwhile absorption was taking place in the arm which caused partial coma on the 10th morning, the whole left thorax was swollen to a tremendous extent, the patient dying the same morning, never recovering from the comatose state. His wife had the grippe, and, I presume, by contagion. She was affected (as I at first thought with tonsillitis) with erysipelas of throat. With energetic treatment

of acon. and bell.  $\phi$ , gtts.  $x$ , in  $\frac{1}{2}$  g.  $H_2O$ , isolation, etc., she recovered after 7 days.

4. A minister, affected with grippe and was treated with quinine, antipyrine, calomel, etc., had never been ill before; but had not had a well day since the grippe; he complained of having had 11 hæmorrhages and was still having them slightly; thoracic and general rheumatic pains in other parts of the body. Temperature, A.M.,  $99^\circ$ , P.M.,  $100\frac{1}{4}^\circ$  F.; history, consumptive. Bry., ham. and phos. in a couple of weeks dispelled all the symptoms; temperature still  $99^\circ$  and  $99\frac{1}{4}^\circ$  F. Gave calc. phos.  $3x$ . The gentleman has not returned again, but I expect the hereditary latent phthisis has been provoked to the front.

5. Grippe treated in the same way as No. 4. Complained of thoracic pains; urine diminished. Temperature,  $99\frac{1}{2}^\circ$  F. Limbs feel bruised; no appetite; slight cough; marked abdominal ascites; cirrhosis (chronic) of liver; urinary analysis, albumin nil; phosphates in excess. Never had any dropsical symptoms before the grippe. The liver, in my opinion, was the cause of the ascites being excited by grippe. Bry.  $2x$  cured all symptoms, but nux vom., ars. and apocyn. cann. dispelled the ascites; the man has been at work ever since and feels well.

A great number of patients in my experience and observance in grippe who were treated with quinine, calomel, antipyrine, teas, etc., were confined to their beds or houses for long periods of time, but more often, as in my 43 office cases, suffered from one or more of the following complications: Supraorbital neuralgia (this species of neuralgia was indeed very common in this locality and seemed to be a sequel of grippe. Acon. and ars. were the prime remedies); intercostal neuralgia (met by acon., ars., bry., rhus tox); enteralgia; coughs; thoracic pains in different localities and of varying intensities; rheumatic pains of various parts with varying degrees of pain, chiefly seated in the lumbar and superior crest and spine of ilium; ovarian neuralgia frequent; amenorrhœa, several cases.

*Treatment.*—In every case, without exception, in this locality, whether the temperature ranged from  $98\frac{1}{2}^\circ$  to  $105\frac{1}{4}^\circ$  F., from the first hour of the attack, the symptoms, as previously given, nothing but acon. and bell.  $\alpha\alpha$  were given. Confinement to bed. Sponging the body, milk and water diet, and I positively state that not a single acute case remained on my hands after my second visit; 24 hours afterward every symptom would disappear in that time and temperature would be normal, and not in a single case thus treated within the first 24 hours from the beginning of grippe did I see any complication appear at the time or afterward. In those cases to which I was called after 24 and within 60th or 70th hours, I first

removed all physical and general symptoms with acon. and bell., and all other symptoms of thoracic pains. Neuralgia, etc., were dealt with by the indicated remedy, generally bry., rhus tox., phos., ars., for any great debility following some cases, china. off. In the pneumonic grippe cases, acon., ars., bry., phos., etc., were used according to their indication.

I am sorry to have delayed sending this paper before. I meant to have written it all at time of date, but professional duties, heat, etc. obliged me to postpone it; I trust, however, there may be some little gleanings in my letter even at this late date, and that you will not ridicule this name of "Pneumonic Grippe" for the want of a better one.

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## INORDINATE PAROXYSMAL PALPITATION OF THE HEART AND ITS TREATMENT.

BY WM. W. VAN BAUN, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania.)

OCCASIONALLY we come in contact with and are perplexed concerning patients with paroxysmal hurry of the heart who present no permanent recognizable disease of that organ, though they may show evidence of temporary dilatation and murmur. This condition differs from the group of clinical cases with persistent cardiac acceleration, known as tachycardia. The attention of the medical world has recently been invited to a consideration of this class of cases by Drs. Bristowe, Broadbent and Samuel West. The characteristic symptoms of the condition are found in individuals, apparently healthy, between the age of thirty and forty, who are suddenly seized with an attack of extremely rapid cardiac action. During the paroxysm the beating of the heart may range from two to three hundred pulsations per minute. Palpitation may be evident to the patient, but, as a rule, they are not conscious of the cardiac flurry. Sometimes præcordial pain accompanies the furious action. The attacks come on in paroxysms, without warning or assignable cause, and may last a few minutes or hours, or even days before the normal pulse rate is re-established. The rapid pulsation may occasionally alternate with great infrequency of the pulse. Dr. Bristowe records a case where two hundred beats gave place to

thirty-four in a few days. There will probably be no other symptoms, and, excepting during the paroxysms, the patients will be in no way incapacitated, and will be capable of attending to the usual occupation, be it either physical labor or mental strain. If the attacks should recur with great frequency, or if they be associated with severe pain and pronounced palpitation, then the patient is placed at a disadvantage and is practically unable to attend to work. The attacks consist of a number of paroxysms at greater or less intervals, the usual course being for them to return with an increasing severity and with diminishing intervals of freedom, although there may be no return for years. Some patients will present signs of organic lesion; the majority on record, however, give no evidence of organic diseases. During an attack the apex may be displaced, with increased cardiac dulness due to dilatation, while cardiac murmurs of varying intensity may be present. All the physical signs may pass away with the attack and no cardiac lesion be left behind. Some of the cases recover while others succumb suddenly to cardiac syncope, or gradually of cardiac failure, where there is no evidence of valvular lesion. This latter condition proves without doubt that cardiac lesion cannot be altogether excluded. The real nature of the affection is still the subject of speculation. Dr. Bristowe regards the condition as purely functional, and in those cases where heart disease was present, he considers the cardiac lesion to be secondary to the attacks of palpitation. Dr. West is of the opinion that cases of paroxysmal hurry of the heart are not due to functional disturbance alone, but that the weight of evidence is strongly in favor of some structural, though presumably temporary, change in the muscular tissue, the valvular tissue not being involved. It has been observed that a gradual failure of the heart is apt to supervene in these cases. Where this condition is present the prognosis is grave respecting both the return of the paroxysms and the ultimate outcome. Dr. A. Symons Eccles has noticed the coincidence of extreme rapidity of the heart's action with floating kidney in four cases, dilatation of the stomach in two cases, and in profuse menorrhagia at the menopause, in two cases. These cases have induced him, in default of pathological evidence to the contrary, to regard prolonged irritation of the abdominal sympathetic, either continuous or intermittent, as a probable cause of paroxysmal tachycardia resulting from reflex inhibition of the vagus, or stimulation or fatigue of the vagus centre, or from the reference of irritation of the sympathetic periphery in the abdomen to the cardiac accelerator fibres of the sympa-

thetic, in the same way as might frequently be noticed in regard to cerebro-spinal nerves of sensation. With the knowledge at hand it is impossible to prove any of these conclusions, yet as many of the recorded cases show antecedents, such as rheumatism, syphilis, together with undue strain as a not uncommon exciting cause, we are naturally led to the belief that the opinion of Dr. West is worthy of great consideration.

CASE 1.—*Sudden collapse: pulse 200–250; with no assignable cause; no murmur; irregular rhythm.* History: indefinite rheumatic; domestic trouble; previous attack, one year ago; recovery. Mrs. A. H., aged thirty-five; married; one child, twelve years old. A frail woman, five feet two inches in height, weighing about 105 pounds. When first seen the patient was almost in a state of collapse, face pallid and distressed. Pulse difficult to count, ranging over 240 beats per minute, rhythm irregular. There was no evidence of cardiac lesion and no symptoms, excepting a sense of impending death. Palpitation was not complained of even on asking direct questions. The patient was immediately put to bed, and as there were practically no symptoms, excepting the objective appearance of a weak, poorly nourished, anæmic woman, with an irregular excessively acting heart and pulse, chin. ars. 2x was given in one-grain doses hourly. The next morning the patient stated that while she had passed an uncomfortable night, she felt stronger and better; she had found that an occasional deep inspiration would produce a grateful sense of relief. There were no symptoms, excepting an indefinable distress which prevented her resting, consequently she had had but little sleep. The pulse was beating 200 to the minute. On examination, the apex was found depressed and situated half an inch to the left of the nipple line, just above the upper border of the sixth rib. The cardiac dulness did not reach upward, but it did extend slightly to the right of the sternum, an impulse being felt at this situation indicating dilatation. There was no evidence of valvular disease. Change of position did not seem to affect either the frequency or the force of the pulse. The remedy was continued with a nutritious liquid diet; coffee and tea being forbidden; the patient being kept at rest in bed. The next morning the improvement was quite marked. The character of the pulse had greatly improved, and averaged 130 per minute. Treatment continued. The next day the patient was up attending to her customary household duties, the pulse beating 90 and the respiration numbering 20. The respirations had never run over 34 to the minute during the entire attack. The urine was normal in quantity, light yellow in color, reaction acid, specific gravity 1020, and it gave negative results to albumen and sugar tests. There was no direct history of rheumatism. For years the patient had been subject to chronic pharyngitis with recurrent attacks of severe laryngitis. She informed me that one year ago she had been troubled with a heating,

or throbbing, in the region of the umbilicus, as if something alive was inside of her. It alarmed her greatly. Continuing for some time, she took some proprietary medicine for tape-worm. The worm, however, did not appear, and the throbbing gradually passed away not to again return. Two weeks after the present attack the patient was as well as usual, the pulse being much stronger and beating regularly at 80 per minute. This attack lasted nearly four days. Five weeks after the first attack, without known cause, while sitting in a rocking-chair, she had a second paroxysm similar in nature to the first; the pulse beating from 200 to 250 per minute. There was this difference, however; the patient did not yield to treatment. Chin. ars., croton tig., hydrocyanic acid., strychnine and tabacum were all given without result. At times her hands and face would be bathed in a cold sweat; as the pulse tension was moderately high glonoin was used; it failed to produce the desired amelioration of the symptoms and had no influence on the pulse. The pulse continued beating steadily at over 200 per minute for more than a week. On the eighth and ninth day, digitalis tinct., in thirty-drop doses, every four hours, improved the character of the pulse but did not lessen its frequency. On the tenth day strophanthus was given in five-drop doses every four hours. On the afternoon of the eleventh day the pulse dropped to 90 beats per minute. The patient regained her customary strength and activity in a remarkably short time. During this prolonged paroxysm she never once complained of dyspnoea. She was very weak, and a constant sense of impending death kept her in a state of mental anguish; there were no other symptoms. During the next six months at intervals varying from three to six weeks, the patient would be seized with attacks of this extraordinary palpitation, although none of the subsequent paroxysms lasted for more than three days at any one time, and frequently they would pass away in six or eight hours; they gradually lessened in severity, the pulse falling from over 200 to 130 per minute. During the interval between the attacks the patient's health was as good as usual, the pulse beating from 75 to 85 per minute. The latter attacks all seemed to be controlled by strophanthus.

It has now been seven months since the patient has had an attack, and she considers herself a well woman—an opinion which I cannot endorse. It is not probable that her attacks were due merely to functional disturbances. In this case the attacks came on suddenly without known cause. The second paroxysm failed to yield to treatment, and gradually wore itself out. The use of strophanthus may have hastened the termination of this paroxysm, as the subsequent history shows that all the other paroxysms were shorter in duration and less violent. The last attack continued about eight hours and caused comparatively little inconvenience.



CASE 2.—*Sudden faintness; anxiety; pulse 240; threatened collapse; cardiac dilatation; no dyspnœa; relieved by glonoin and tabacum; recurrent attacks; rapid restoration between attacks to general health; recovery.*

Mr. H. K., aged 30, hardware clerk. He had been feeling as well as usual, when on stooping over to lift a package from the floor he was taken suddenly ill, with a sensation of nausea, extreme prostration, and a distressed feeling in his chest. He was given a drink of whiskey, sent home, and put to bed. When I saw him his pulse, while soft and weak, was beating regularly and distinctly 240 pulsations per minute. He seemed to be bordering on a state of collapse. His only complaint was a sense of faintness. This was associated with considerable anxiety and mental excitement. There were no indications of cardiac lesion, there being neither murmur or friction sound. The apex was to the left of the nipple in the fifth interspace, diffused two finger tips in breadth. In this case I was fearful lest the patient would die of a heart paralyzed in diastole. One-drop doses of the third centesimal alcoholic solution of glonoin every three hours in ten hours produced an extremely gratifying result. The cardiac action was slowed and the danger averted. For the next six days the patient was anæmic and bathed in perspiration. While he remained in bed he seemed to be perfectly well. The instant he would leave his couch the pulse would jump from an even hundred up to two hundred and over. This was associated with a sickening anguish which he could not express. On the third day there was no apparent change for the better; the symptoms indicated a degree of chest oppression without pain. The patient complained constantly that a great misfortune had happened to him, the nature of which he was not able to explain. His pulse was 150, and his skin was bathed in perspiration. He was placed on tarantula 30. On the seventh day, to my surprise, the patient, excepting his weakness, became suddenly as well as ever, the pulse being normal. Three days later the signs of dilatation having passed away he returned to his business. Eight weeks after his first paroxysm he had a second attack. In addition to the peculiar sick distress and pallor he stated that he had been annoyed with an alternating diarrhœa and constipation, an occasional sense of palpitation, *muscæ volitantes*, *tinnitus aurium*, and at times a dry cough.

The pulse when felt was beating 200 to the minute, and at this time there was no complaint of palpitation. The patient not using tobacco, he was given tabacum 30th, and the attack terminated in three days. During the next four or five months, ending April, 1889, since which time I have not seen him, the patient had a number of paroxysms of excessive heart-hurry, the severity of the paroxysms gradually ceasing and the free interval lengthening. Tabacum 30th always seemed to give him relief. Careful physical

examination showed the man to be to all intent and purpose organically sound. Yet from some hidden cause he suffered from paroxysms of the most rapid heart beating, lasting at times from three to twenty hours, that I had ever seen. After the cessation of the attack the rapid return to usual health was astonishing. Another strange factor in this case was that he never complained of a sense of palpitation during a paroxysm. General treatment: Naturally in desperate cases with threatening cardiac paralysis we turn to stimulants like alcohol and ammonia, or to the more rapidly acting heart tonics, amyl nitrite or glonoin; the latter while not quite so prompt in action as amyl nitrite is much the safer drug. In the first of the two cases related at length glonoin proved to be of absolutely no value, while in the second case it produced a condition that was less dangerous than before it was given, but its continued use failed to produce curative results. In the first instance, after using many remedies, strophanthus proved effectual, and in the latter case tabacum 30th produced results that could not help but be gratifying. My experience being too limited to mark out a clear-cut line of treatment, I look for good results from the group of similarly acting remedies such as amygdalæ am. aq., amyl nit., atropium, chininum ars. and sulph., glon., jaborandi, kali nitr., naja trip., pilocarpinum strychninum, tabacum, thea., and, lastly, digitalis and strophanthus. The patient is to be placed on his right side in as near a horizontal position as possible. Huchard recommends a spray of bichloride of methyl to the præcordium, the back of the neck or to the chest. When the cardiac weakness is very marked and syncope is present direct cardiac stimulation is necessary, such as has been suggested above or by means of hypodermic injections of ether or caffeine, together with inhalations of amyl nitrite. During the interval between attacks coffee, tea, alcohol in any shape and tobacco are to be strictly forbidden.

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### THE PROTECTION OF THE PUBLIC AGAINST TUBERCULAR CONSUMPTION.

BY PEMBERTON DUDLEY, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the County of Philadelphia.)

IN introducing to an audience of physicians the subject of pulmonary tuberculosis in any of its aspects there is no need to make more than the briefest allusion to its merciless and intractable nature, or

to its vast destruction of human life. And there is another feature of the malady which is sufficiently apparent to medical practitioners, but which is unappreciated by the mass of our fellow-citizens—its destruction of property. I allude to this feature of the disease here because it is probable that only by the forcible presentation of this fact can the public mind be sufficiently impressed with the necessity of effectively combating it. The public should be brought to see, as the physician sees, that when this blanch-faced enemy, consumption, enters a household, that a merchant's store is closed, an accountant's ledger is balanced, a journalist's pen laid down, a preacher's voice silenced, a teacher's desk forsaken, a workman's bench abandoned, and, as a consequence, an income cut off, and cut off not to be again restored. It is not so with an invasion of typhoid fever, or pneumonia, or rheumatism, nor even in the presence of the most malignant epidemics. *These involve a suspension of income,—that an arrest.* And all too soon, in many instances, the family accustomed to the comforts of a loved home is scattered and thrown upon the partial or entire support of charity.

Pulmonary consumption chooses its victims from that class of people who are either just about completing their growth and education preparatory to entrance upon life's activities and responsibilities, or are in the prime of their productive usefulness. The period of greatest danger is included between the ages of twenty and thirty years, and there are very few cases to be discovered before the age of fifteen or after fifty, though there are more in old age than in childhood. The average age of the victims is probably not far from twenty-five. In computing the pecuniary loss from a fatal case of consumption, we might estimate the cost of maintenance during the unproductive years of life, and the time and cost of education. But a more accurate mode, it seems to me, is to calculate the amount of money likely to be earned by the individual in case he escapes the ravages of phthisis.

According to the tables of "Expectation of Life," based as they are upon the facts as they exist, and not upon the facts as they would exist, were tubercular phthisis banished from the face of the earth, it is safe to say that the man or woman who reaches the age of twenty-five in reasonable health might justly expect, in case tubercular consumption could be avoided, to live thirty years longer, *i.e.*, to the age of fifty-five. Assuming, however, for the sake of safety, that the limit is but twenty-five years, and we have before us the fact that the average victim of consumption involves to the commu-

nity, and chiefly to his family, a loss of twenty-five years of productive industry.

Next, let us assume that the average healthy man between the ages of twenty-five and fifty years can and does produce, over and above his own maintenance, work to the intrinsic value of \$5 per week, and the average woman \$3. (Will any one say this estimate is extravagant?) We shall thus have, as the average of the two sexes, \$4 per week, or \$200 per year, or \$5000 for the twenty-five years, which consumption cuts off from its victim's life. Then, assuming the average death-rate from consumption in this city to be fifty per week—I believe it is somewhat higher than that—we have the well-nigh incredible fact that pulmonary consumption cuts off from the present and prospective wealth of the city of Philadelphia \$250,000 per week, or \$13,000,000 per annum.

Yet, startling as the financial side of this great sanitary question may be, there are those who, having felt the ravages of consumption in their own homes and hearts, will vigorously protest against having this cold-blooded estimate of dollars and cents placed beside the anxiety, the suffering and apprehension, the bereavement and the consequent privation that cast their black shadow into thousands of Philadelphia homes every year. Like that other arch enemy, the saloon, consumption stings the head of the household in many instances, and the whole family withers and scatters beneath its blighting power.

What shall the physician do—what *can* he do—in his capacity as a sanitarian, and what can the public do in staying the progress and crippling the power of this destructive malady? For it is a question not alone for the physician, but also for the patriot and economist; and, above all, for the educator, the journalist and the clergyman. But first the physician must acquire a correct and thorough understanding of the causing and predisposing factors in the production and propagation of the disease, and in the second place we must modify our views as to our power over it. Christianity—if it be an intelligent Christianity—must believe that a time is coming when tuberculosis, like other evils, shall be driven from among men, and science does small credit to herself by being less hopeful. To decide the disease to be incurable and unpreventable, to accept the final view that phthisis is destined to run side by side with moral and intellectual enlightenment through all future history, were a lame and impotent conclusion indeed.

Science, however, is sanguine of improvement even if conserva-

tive in her promises. Already the investigations that are being made into the ætiology of phthisis are pointing the way both to its cure and its prevention. It will interest us to consider the results of these very briefly.

The influence of heredity, it may be said, in the first place, is responsible for a much smaller percentage of phthisis cases than is popularly supposed; certainly not more than fifty per cent., even including the broad "family predisposition" insisted on by Dr. Williams. And if we deny the infallibility of evidence as furnished by cases occurring in collateral relatives, we must reduce this estimate to twenty-five per cent., if not to twelve, as the proportion of cases determined by heredity. Admitting the percentage to be twenty-five, how sharply it contrasts with the popular and the older professional view of the determining causes of phthisis!

Aside from hereditary predisposition, we may mention the following prominent accepted causes of pulmonary phthisis, and as we mention them let us observe to what extent they are under the control of the sanitarian, the physician or the patient himself.

*First.*—Exhausting and debilitating conditions, such as (a) long-continued and frequent menorrhagias, leucorrhœa, miscarriages, extensive abscesses, etc. (b) Deficient nourishment or insufficient oxygenation of the blood. (c) Exhausting dissipations, *e.g.*, late hours and deficient sleep, the alcohol habit, sexual excesses, etc.

*Secondly.*—Zymotic diseases, typhoid and typhus fevers; the exanthemata—prominent among them being small-pox, scarlatina and measles. Malarial fevers.

*Thirdly.*—Local diseases of the respiratory organs—laryngitis, bronchitis, pneumonitis, pleuritis and their combinations.

*Fourthly.*—Climatic and local influences; the more prominent being a damp atmosphere and a water-saturated subsoil, as demonstrated by Drs. Bowditch and Pepper.

*Fifthly.*—Inhalation of dust and especially of mineral or gritty dust.

*Sixthly.*—Infection from pre-existing cases—by inhalation, ingestion, inoculation, etc. (By this latter term I allude to accidental, *not* experimental inoculation.)

It will doubtless be admitted that in the above list are included the causes of nine-tenths of all the cases of phthisis occurring independently of hereditary predisposition and the *exciting* causes of nearly all the "hereditary cases," also. It will also, I am very sure, be admitted yea, asserted, that the operation of nearly or quite

all these causes is clearly within human control, even with our present knowledge. In other words, that fifty to seventy-five per cent. or upwards of the cases of consumption, occurring in Philadelphia as elsewhere, are due to causes within the knowledge and largely within the control of medical and sanitary measures, and that it is already possible to so reduce the number of cases by efficient public and private sanitation and preventive medical treatment, as to save from twelve to eighteen hundred lives and six to ten millions of dollars per annum. I do not mean, of course, that by one mighty effort we can stay this awful destruction of life and money; but I do mean that the loss of all these lives and all these millions is *not* a foregone conclusion—is *not* inevitable, but that we have here a broad and most promising domain for the exercise of our sanitary efforts.

I have recently been interested in making some inquiries among my professional friends as to the probable percentage of phthisis cases traceable to infection from pre-existing cases. With this object in view, I addressed to a considerable number of physicians a note asking for information on this matter, being careful to select only those in whose capacity for careful observation I could have full confidence. In response to this inquiry thirty-two replies were received. These replies, when collated, show that the writers had 167 cases under observation, and of this number 14 cases occurred under circumstances suspicious of infection from a pre-existing case. This proportion is by no means so great as I expected, being about 8½ per cent. of the total, and yet it is sufficiently large to emphasize the necessity of extreme precautionary measures on the part of those having cases of tubercular phthisis in charge, either as physicians or as nurses.

There is another mode of infection, however, which probably accounts for a still larger percentage of cases, namely, through tuberculous meat and especially through tuberculous milk. That our domestic cattle are liable to the disease is well and widely known, but the extent to which the disease prevails in our Pennsylvania herds is not at all appreciated. Secretary Edge, of the State Board of Agriculture, has made some statements recently, in a conference with the State Board of Health, to the effect that in our eastern and southern counties, even among our blooded cattle, as well as elsewhere throughout the State, tuberculosis can be found extensively prevalent. The great danger from such a source of infection is to be found largely in the inability of the average dairyman to diagnose the disease save in its extreme stages, and in the cupidity which

hesitates at no misdeed short of a penal crime where money-getting is the object. Not that our farmers are one whit worse than other men ; their act is on the precise level with that of those who kill their fellows by confining them in unventilated workshops, factories and school-houses, or by compelling their saleswomen to occupy the erect posture five hours at a time, or by polluting the sources and streams of our water supply, or by encouraging and tempting our boys and girls to form the alcohol habit, or to indulge in still lower forms of dissipation. The excuse formulated by one of these offenders is that rendered by all the others : " I am merely attending to my legitimate business ; let other people look out for themselves. I do not think I am doing much harm at any rate." Philadelphia has found it quite difficult to protect her citizens against such a peril as that under consideration, simply because her authority does not reach to the dairy farms beyond her own borders—the source of almost her entire milk supply. Her present system of milk inspection, so far as the danger of tuberculous infection is concerned, is of no value or efficiency whatever.

Now as to practical sanitary measures for the protection of our people against this disease. As was said at the beginning of this paper the work and the responsibility fall first upon the physician, but afterwards upon our educational agencies of whatsoever kind, and largely upon our private citizens. Looking again at the predisposing and determining causes of tuberculosis we shall be impressed with the fact that whatever lowers the vitality in almost any manner becomes a causative antecedent in the development of tubercle, and, *per contra*, any measure, public or private, which elevates the health of the community or of the single individual tends to the prevention of this dangerous process. In so far as we can diminish dissipation in its fashionable as well as in its more degrading forms, in so much as we may prevent extreme poverty, in so much as we enforce the physiological demands for pure air and cheap and abundant food, for pure water and proper clothing, in so far as we can bring under sanitary supervision our workshops and factories, our stores and counting-rooms, our schools and churches, our street cars and steam cars, by just so much shall we elevate the average of public health, by just so much diminish the ravages of pulmonary tuberculosis.

Then we shall need, and we ought to have it *now*, a thorough and all-embracing system of inspection, under which all food production, as well as all food commerce, shall be forced under the rules and precautions of sanitary science and art. People are all constituted

alike. There are thousands of people who would make any personal sacrifice rather than involve another in unnecessary danger. And there are thousands of others who, while they would not deliberately destroy life for paltry gold, will, for the sake of a few dollars, place an employee, a neighbor, or even a whole community in needless danger to health and life. Such people need not education, but legal supervision and restraint.

A word about heredity as a factor in the ætiology of tuberculosis. While there can be no question that the tuberculous predisposition is hereditary, is it not equally true that health is also hereditary? While a healthy line of descent can be broken into and deteriorated by tuberculous agencies, is it not also true that by a careful and persistent course of physiological methods even the tubercular heredity may after a time be overcome? In support of such a view we have the fact that tubercular consumption, after committing grievous havoc for a generation or two, disappears for a time not to reappear for several successive generations. If it can be thus held in abeyance for a time, why not indefinitely?

The restriction of marriages as relating to persons affected or threatened with phthisis is probably the most difficult part of the sanitary problem before us. And yet we find that in reference to hereditary insanity, cancer and alcoholism, public sentiment has been so influenced as to affect in a marked degree the freedom with which persons thus affected may contract nuptial alliances. We may venture the hope, I think, that a pronounced and emphatic professional sentiment, freely and vigorously expressed on all proper occasions and supported by the active influence of the newspaper and pulpit, will yet greatly modify our popular customs in even this important particular.

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#### CONSTRICTIONS OF THE INTERNAL OS THE CAUSE OF REFLEX CONDITIONS.

BY G. E. COGSWELL, M.D., MT. CARROLL, ILL.

(Read before the Association of Official Surgeons.)

ORIFICIAL philosophy although yet in its infancy, is already too great to be compassed in the time allotted to any one paper, though the writer possessed the necessary ability to properly discuss so great a subject. While we now have some rays of light from the great truth underlying it, yet I believe the possibilities of orificial sur-



gery are far beyond our wildest dreams and vivid imaginations. If one were to half express them he would stand in danger of being considered a crank even by this society, and by the medical profession at large, as a fit subject for the insane asylum. Although we may not fully appreciate all the benefits that will accrue to suffering humanity from the application of orificial surgery, some of its fundamental principles are already known to most of the members of this society. It is by reason of the knowledge of these principles as a common plane, that we meet to-day to exchange our experience and increase our store of information, and thus acquire an added zeal for the successful advancement of the cause. This then is the only apology I would offer for bringing my mite to be placed by the side of greater contributions from far abler pens. The subject I have chosen, is one that has been in my mind for some time. Probably many of you have had similar experiences and arrived at like conclusions.

I think it was from a study of constrictions of the internal os, as the cause of reflex conditions, that I obtained the first glimpse of the marvellous action of the sympathetic nerves over the capillary circulation, the disturbances of which produce those reflex conditions that have so long baffled the skill of the medical world, and now are so easily removed by proper surgical measures. It is well known to students in orificial surgery, that upon the condition of the internal os depends in a large degree the well being of woman. It is the place where the neck joins the body of the uterus, where the important blood-vessels, nerves and lymphatics find their entrance and exit, and where the only fixed supports of the uterus are attached. It is the very centre of the female sexual system, and as such, becomes an important part and one to which our attention should be directed in making a diagnosis of many of the reflex conditions which we are called upon to relieve.

Strength at this point means normal position of the uterus and generally normal health in consequence. While weakness, irritation, spasm or other abnormal condition, means congestion, inflammation, flexion and any or all the disorders to which the uterus is subject. It can to a great degree favor or prevent conception, and the exciting cause of an obstinate dysmenorrhœa is many times revealed by a careful examination of the condition of the internal os, and canal of the uterus. While old lacerations of the cervix and the external os that have partially healed, and those that are still the seat of irritation, have been recognized by all our leading gynecologists as a

cause of certain conditions, and our literature on this subject is largely a description of operations that have been recommended for the cure of such, it remained for orificial surgery to demonstrate the fact that constrictions of the internal os that were not due to lacerations, was the cause of many reflex conditions; thus we find that a study of orificial surgery is a study of reflexes in which the internal os plays no mean part.

If metastatic irritation of the cerebro-spinal system can cause tetanus, paralysis or other general troubles from injury to the terminal nerve fibres, the same is also true of the sympathetic nervous system; and orificial irritation can induce any organic, general or particular disorder by reflex action. It is a well-established fact that practically, all chronic disorders are actual pathological states, *i.e.*, abnormal conditions characterized by structural alterations. Even those disorders that have been looked upon as purely functional are simply misdirected nerve force, and are due to irritations of terminal nerve fibres, which irritations are easily discovered, and in the great majority of instances, may be removed and corrected.

It is an axiom of orificial philosophy that the irritations of an organ begins at its mouth. It follows therefore that a constriction of the internal os may cause corporeal endometritis and all the other disorders to which the body of the uterus is liable. Rectal congestions, indigestion in all its various forms, kidney and liver disorders, lung, heart, brain and spinal affections, and all kinds of circulatory and nervous troubles, are at times the result of irritations at this part. While these disorders may be induced by irritations of the other orifices of the body, yet we think that no case of chronic disease in woman is properly diagnosed until a thorough examination of the internal os has been made. Congestions, inflammations, and severe local irritations have a circumscribed area of action while their intensity lasts, but when they begin to complain in the language of reflexes, the local irritations largely subside and are easily overlooked; hence it is that great care should be taken in making a diagnosis, and no point should be passed by until we are satisfied that there is no irritation present. Although there may be no malposition of the uterus, no erosions, nor ulcerations, nor even leucorrhœa, in fact there may be no local symptoms of abnormal condition present, still we may find that an atrophied uterus or a stenosis of the canal or internal os, is the key to the ill-health and explains why we have failed in our former efforts for relief. After having determined the cause to be

irritations of the internal os, then the question of removal is one that we can well afford to discuss. To a student in orificial surgery there is but one answer, and that is free vent by thorough dilatation and the removal of all points of irritation. If we remove the cause, the effect will also leave.

Now it is not in every case that you can dilate and excise a few sphincters and say to the case, be well; for never since the totality of the symptoms as a safe guide to correct prescribing was taught has there been a greater need of individualization in a given case than since orificial surgery was recommended as a cure for chronic troubles, and the amount of judgment exercised in a given case is measured by the results obtained. By this standard are we to judge of and determine the skill of every one who would aspire to the title of Orificial Surgeon.

It is well known that nature cures her women of many ills by dilatation of the uterus consequent upon child-bearing. We have seen the delicate maiden of twenty become the robust mother of twenty-five or more years. How many times have we, as physicians, recommended pregnancy as a remedy for many of the abnormal conditions and enfeebled states of the young wife. However, this is a severe method, and ought not to be indulged in too often, or else there will not be sufficient time for recuperation, and a greater evil will be the consequence; the whole system becomes tired and the difficulty is increased, thus making the latter condition much worse than the first. From this it will be seen that nature does her work thoroughly and then awaits results. Does not the same law hold good in orificial work? Are we not striving to accomplish in an artificial way what nature does physiologically? Is it not possible that we have been a little too timid in our first work and a little over-anxious on our after-treatment? May we not, then, learn a lesson from a study of nature and nature's laws, *i.e.*, dilate thoroughly the uterine cavity as well as the sphincters, removing all points of irritation, and then giving ample time for reaction before we begin the after-treatment. This is the general rule which all must admit, for it is as self-evident as the advice we used to have from the old professors: "Study the case well and give the indicated remedy." I believe at this point is determined the difference between the mechanic and the physician, for on our ability to tell when a case should be let alone and when there should be interference, will depend, in a great measure, our success as orificialists. It is not enough that we are able to operate well, but we must also be qualified to determine what operation is

needed and when it shall be done, and what after-treatment will be needed. It will not do to simply do the work and expect the case to make a brilliant recovery, for there are some systems so sluggish that frequent dilatations will have to be made until the point of reaction is reached, and then they must be allowed to remain quiet for nature to do the rest. Then there are other systems so sensitive that a little overwork will overpower them, and perhaps carry them beyond the chance of recovery. These cases demand careful handling, if we would not increase rather than diminish their trouble.

In confirmation of the above statements I will relate a few cases in my own practice, as taken from my notes.

CASE No. 6: *Chorea with Complications*.—Miss W., aged 28, came to me about two years ago with the following symptoms: A constant pain in the back across the hips; severe pain in the left breast; there was no appearance of any trouble in the breast, except the pain, neither swelling or redness; pain in the top of the head, severe lancinating pains on urinating, which was too frequent; menses regular; leucorrhœa most of the time; bowels regular, but about every week or ten days she would have an attack of hæmorrhage from the bowels of a half-a-pint or more. This would last for sixteen or twenty hours, and was accompanied by great pain. When the pain became too severe she would have an attack of spasms which would last from twelve to forty hours, and which nothing would control but chloroform. These attacks had continued at regular intervals for fourteen years. She was debilitated, nervous, and becoming moody, as if bordering on insanity. I commenced the treatment of the case with the use of the battery, and succeeded in warding off the attacks for five months, the longest time, by four months, that she had escaped the attack in fourteen years. Then the battery seemed to have lost its effect. I then concluded to try what orificial surgery would do for her. I gave her an anæsthetic and found the hood adherent to the clitoris, the vaginal walls were hard and tough, the uterus small and flabby. I loosened the hood, stretched the vaginal walls, using the sharp curette to remove small protuberances and start nutritive changes, dilated the uterus to No. 16 sound, wiping it out and removing nearly a spoonful of granulations. In the bowel there were several papillæ and a few pockets, and on the anterior wall there was a large sack filled with pus, which discharged nearly a tablespoonful when we opened it. After dilating the sphincter we removed her to the bed, where she remained two weeks. For several weeks she seemed to gain rapidly, and at this time I thought to hurry up the case a little, when, on attempting to dilate the bowels, she immediately had one of the most severe spasms that she had had for over a year.

From this the spasms seemed to return. I then put her under the influence of ether a second time, and with the assistance of Prof.

Pratt we dilated the canal of the uterus, the vagina, urethra and rectum. She again made a fair recovery from the operation, and this time the improvement seemed to last for about nine months, when some of the old symptoms returned. I did not try to dilate the sphincter without an anæsthetic, but for the third time gave her ether and again thoroughly dilated the parts. I found the same constriction and contraction that existed on the former occasions. I then made a submucous section of the sphincters, dilated the cervix and waited results. She made a more rapid reaction from the operation, and, as far as I can judge, is going on to complete recovery. If we shall succeed in curing the case I believe it will be due to the repeated dilatations, as I doubt if it was possible to effect a cure in the case with a single operation.

CASE NO. 17. *Constriction of the internal os with reflex conditions:* Miss A., aged 31, applied for relief from what has been variously diagnosed by thirteen different physicians as neuralgia, heart disease, consumption, congestion of the spinal cord, rheumatism, dyspepsia, nervous prostration and impending paralysis. For seventeen years she had been a sufferer at the hands of the medical gentlemen who subjected her to all sorts of treatment. One more heroic than the rest treated her with red-hot irons along the spinal column in the vain hope of relieving a supposed congestion of the spinal cord. Nine of the seventeen years she was too weak to sit up and had to remain in bed. Examination revealed the fact that the uterus was small and hard with constriction of the internal os and amounting almost to stenosis of the canal; the sphincters were loose, and on being dilated they remained open for a few minutes before they contracted. There were two or three little pockets, which were removed, and the uterus was thoroughly dilated and cleaned out, and as an evidence of the low vitality will say that she felt comparatively little pain during the operation, which was done without an anæsthetic. She seemed to gain almost immediately, so much so that I was astonished. The improvement thus begun continued from day to day. In four weeks I made another examination and found the uterus nearly three times its former size and quite sensitive to the touch. The former troubles had all disappeared and returning health was plainly visible in her general appearance. I gave her no further treatment and the case has gone on to complete recovery.

The third case of which I will speak is No. 39 in my case-book, and was one of peculiar interest to me.

Miss S., aged 29, spare habit, narrow chest and slight form, a teacher in the public schools. For five years she had been failing in health, had attacks of dyspnoea, and at times pains in the lungs and some soreness in the right lung. Was constantly tired, had a poor appetite and sluggish digestion. During the last year has had

four attacks of what was thought to be neuralgia of the heart. There was irregularity of the heart's action, and at these times there was a dry hacking cough with little or no expectoration. When I first saw her in January she was unable to lie down on account of the dyspnoea and too weak to stand on her feet. She had remained propped up in her chair two weeks, with constant panting for breath, very great prostration, and complete lack of appetite, her feet cold and somewhat swollen, temperature  $96.5^{\circ}$  F., with the skin dry and hard. The menses were regular, and she assured me there was no trouble there, for she had been examined a year before by an eminent gynaecologist, and he had said that there was no trouble within the uterus; also she was sure there was no trouble with the bowels and she had never experienced any inconvenience in that region. I made as thorough an examination as her enfeebled condition would permit and thought the trouble originated in a constriction of the internal os, as well as tight sphincters. I commenced the treatment by dilating the sphincter and replacing the uterus, which was retroflexed, three times a week. This was too active for her and so I tried it but twice each week. She began to improve, and in two months she was able to walk a mile a day. We then decided to operate, and found the uterus small, hard and almost fibrous in its texture. In the meatus urinarius there was a small abscess or pus pocket the size of a small bean. The uterus was thoroughly dilated, and also the sphincters. There were a few pockets in the rectum which were served in the most modern way. The operation was performed by Prof. Pratt at the Lincoln Park Sanitarium. She made decided improvement in a short time, and in six weeks returned to her school in better health than at any time before in five years. I believe she was too weak for an operation at first, and had we undertaken it, might have snapped the brittle cord that bound her to life, but by first dilating by degrees as she could stand it, we aroused a reaction that finally enabled her to undergo the operation with safety, and a brilliant cure was the reward for the exercise of judgment in the case.

These cases illustrate what constrictions or irritations of the internal os will do. To me they were revelations, not only as to the cause of many reflex troubles, but also as to the necessity of careful as well as thorough treatment. In neither was the local trouble prominent enough to attract the casual observer. The offending part is very often obscure in chronic reflex irritation and is liable to be overlooked owing to the fact that it is seldom the seat of pain and the inflammation is sub-acute.

It is very important that we as orificialists should acquaint ourselves with all the phenomena attending constriction or other irritations of all the orifices of the body and especially those of the internal os and the canal of the uterus, for much of our success will

depend on our ability to not only diagnose these reflexes, but to remove the irritations that cause them; and many an afflicted woman may be saved years of suffering by proper official work.

These cases had continued to exist in spite of all treatment until the cause was removed. The first required persistent efforts and radical treatment to produce the desired results, and anything short of repeated dilations, to the fullest extent, would have failed to effect a cure.

The second needed but a single operation and that of the mildest kind to start nutritive changes that brought complete restoration.

Had we been over anxious and tried the routine after-treatment it would have been disastrous in its consequences.

The third case demanded the most delicate treatment at first to arouse nature to begin the repair before thorough work was possible.

Thus it will be seen that individualization is absolutely necessary if we would have the happiest results with these delicate cases. For in official surgery we have a mighty power, and one that is capable of doing much good if rightly used, but if we attempt to put all cases through the same routine we will find that this very power is capable of doing a correspondingly great harm.

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### IS AMALGAMATION POSSIBLE?

BY S. LILIENTHAL, M.D., SAN FRANCISCO, CAL.

AT the meeting of the California State Homœopathic Medical Society I had the pleasure of presenting a paper bearing the title "Thou Art So Near and Yet So Far," in which I gave full credit to Professors Harnack, Arndt and Schultz for their endeavors to free the therapeutics of the old school from the stigma of mere empiricism. Arndt and Schultz claim, if there is any truth in biological researches, that the relations between large and small doses can only be understood by acknowledging that which might be considered a small dose for a healthy organ may be a very strong one for a deranged organ, and Harnack teaches that even a single cell has its own psychical life, and that there are millions of such infinitesimal psychical micro-organisms in our bodies; still when it comes to a practical demonstration, we find that all is not gold that glitters, and the millennium of amalgamation is just as far off as ever. I

feel sorry that so many physicians who claim to believe in the truth of Hahnemann's law, pride themselves in their aberrations and claim too often the right to cure their patients by the best road known to them, when a better study of the *materia medica* and a closer application of the principles of homœopathy might teach them, that the fault lies within themselves and that the remedy is near at hand. The very theory, proclaimed by high authorities of the old school, how deranged functions are rectified by apparently small doses, but which are in reality powerful stimulants to the diseased cells, ought to convince them that the dose of a drug is of the utmost importance, and that in many cases our failures may be attributable to the paralyzing effects of the large dose, though the same quantity might be considered too small to show any action on the healthy cell. But my aim at present is to show from one of the best writers on allopathic *materia medica*, *Lehrbuch der Klinischen Arzneibehandlung*, by Dr. Franz Penzoldt, Jena, 1889, that amalgamation is an impossibility, and though patients recover under any or no treatment or succumb to the inevitable law of nature, still that strict individualization in relation to patient, to the diseased cell and to the drug employed can only be carried out by complying with the teachings handed to us by the fathers of our school.

Prof. Penzoldt makes experience the basis of therapeutics, the clinic decides what to use and in what doses it ought to be prescribed, and he is thus in full accord with the French school as taught by Dr. Jousset and his staff at the Hospital St. Jacques. Let us quote here some ideas of Penzoldt's.

"On the medicinal action of drugs the opinions of physicians are still too much divergent and many drugs formerly in good repute, are now-a-days thrown among old lumber. One cause of this divergence may perhaps be found in the impurity of drugs employed, and the results must vary whether one employ a pure or an impure, or perhaps an adulterated substance. Another obstacle in the treatment of human ailments is that diagnosis leaves still too much to be desired. Two cases may show nearly the same complex of symptoms, and still their courses differ, and obduction shows different processes. Pictures of diseased states, known under one and the same name, offer valuable differential points in each particular case, and to elucidate these differences is nearly impossible in the present condition of diagnostic science. It is therefore of the utmost necessity, *not only to differentiate the morbid states, but we must also take full account of the personality of the patient, and then we must also strictly individualize the drug and its various medicinal actions.* Moreover, the observations of the attending physicians cannot always be relied



on and many errors will creep in, and it were a wrong idea to teach to try one drug, if the first one failed, and so forth, or to mix a whole lot together into one prescription, so that perhaps one of the ingredients might hit the nail on the head. It is also a pity that subjective symptoms will more or less deceive, and one has to be very careful not to talk symptoms into the patient. Objective symptoms, the physical examination, are certainly of higher value when carefully recorded, and even then every bias ought to be carefully excluded."

I wonder whether Prof. Penzoldt took these ideas from the *Organon*, for this threefold individualization, the totality of the symptoms (subjective and objective), the single remedy, are the principles on which homœopathy is based, but when we come to their practical application, we, in sorrow exclaim, "Thou art so near and yet so far!"

Penzoldt begins his treatise with an inorganic drug, and introducing hydrargyrum he speaks of its high therapeutic action as an anti-syphilitic, antiseptic and purgative, mentioning also the use of calomel as a diuretic, but doubts the power of mercury to act as an antiphlogistic or resorbent. Though highly praised by others, Penzoldt doubts the benefit ascribed to the mercurials (corrosive, the iodides, and the cyanide) in the treatment of diphtheria. If he and his school would only individualize the drug, they would find out the plethora curable by it. In the treatment of syphilis we are nearly in perfect accord with him.

Physiology fails to explain the action of *ferrum*. In all the blood of the human body there is only 3.0 iron and 0.05—0.1 daily iron suffices to make up for its loss in the hæmoglobine in the destroyed blood-corpuscles, and thus he cannot explain its action in chlorosis. He believes the benefit arises more from hygienic living. Iron must be given in very small doses, several times daily, and ferruginous water taken at the springs, plus air, exercise and suitable food, are his panacea. In acute anæmia, as after hæmorrhage, as well as in chronic anæmia or in cachexia it never does much good and febrile diseases are a standing contraindication. He has only slight hope in it as a hæmostatic, as small doses fail and large doses may produce embolism. How different from the teachings of Schüssler, whose *ferrum phosphoricum* has unjustly, with some, nearly pushed aside the use of aconite, gelsemium and veratrum viride, when the indications for each of them are so widely different.

*Cuprum sulphuricum* is a good emetic, acting quickly, and that is

all, except as a caustic externally, but workers in copper seldom contract Asiatic cholera, and this in the spasmodic form has done good service. Lack of reaction in persons who are thoroughly run down by over-taxing mind and body and who fail to recover on account of relapses is another keynote for cuprum, as the whole nervous system is distressed; convulsions are only the outward symptom of this want of tone.

*Zincum oxydatum* was formerly much praised in convulsive neuroses, especially in epilepsy of young people, but is now out of fashion; the sulphate of zinc is another emetic, and also used externally in catarrhal conditions as an astringent, but as a caustic the chlorate of zinc is preferable.

The old school fails again to differentiate. While zincum gives us undeveloped diseases from enervation (night-watching, etc.), in cuprum the eruption fails to come out owing to the spasmodic condition of the whole vasomotor nervous system. Nervous depression and its sequels are the keynotes for zincum, and its fidgety unrest makes the patient irritable. We find paralysis in zinc, but not in cuprum.

*Argentum nitricum* may be given in *tabes dorsalis* when everything else fails; and too often it will fail; also in chronic gastric catarrh or in gastric ulcer it certainly cannot be dispensed with. It gained great reputation by its external use as a caustic. Used as an injection, benefit was witnessed in dysentery and gonorrhœa.

Will the old school ever learn to individualize the drug? What a great neurotic remedy silver is in our school and far more useful in functional than in organic nervous disorders, like locomotor ataxia. How often has it cured gastralgia and migraine (especially when engrafted on an hysterical basis)? Pure nervous asthma and angina pectoris have yielded to it when other remedies failed. Will it cure epilepsy, even when the pupils are dilated hours before the attack? We doubt it, except that the emotional element prevails, when it also will cure a diarrhœa from the same cause.

*Plumbum* can well be spared for internal use; externally it has always been used as an astringent.

Knowing that it causes constriction of the muscular fibres, we use it in colic when there is such a constriction that the abdominal wall nearly touches the vertebræ. Constipation is a natural consequence with the constrictive sensation as though a string was drawing the anus up into the rectum. But the reverse of over-excitation is

paralysis and we find lead therefore sometimes suitable to the latter state. In fact, sclerosis is here the keynote.

The chromium preparations are regarded by Penzoldt only as caustics. For kali bichromicum he gives no indications worth anything, while no physician of our school would like to be deprived of its use. How beautiful it works in all inflammations of mucous membranes with their fibrinous exudations and tendency to form membranes, and its ropy and stringy discharges. We too often think only of it in croup or diphtheria, perhaps also in gastric affections, but neglect it in rheumatic affections, and more still in that asthma from bronchial dilatation with tough tenacious exudation, in patients who cannot stand damp cold weather.

Penzoldt thinks a great deal of *bismuthum subnitricum* in chronic diarrhoea, but it must be given in large doses. He considers its use superfluous in cardialgia or other gastric affections, while we use it in nervous gastralgia with much burning in the stomach and violent ejection of food.

*Alumen* or *aluminium* spoils the appetite when given internally, but people use it as a gargle in catarrhal affections of the mucous membranes.

Poor old school! The large symptom complex of alumina shows its indications in scrofulosis, in chlorosis and anæmia, in tabes dorsalis, dryness of the mucous membranes, hence often so useful in the constipation of infants, in dry and rough eruptions, in dry and spasmodic cough.

The salts of *magnesium* act as antacids and as purgatives, so says Penzoldt, and that is all. How often do we witness the beneficial action of the carbonate in affections of the gastro-intestinal organs, where it acts similarly to colocynth, while the chloride of magnesium suits so well hysterical women or persons whose hepatic functions are out of order, with palpitation of the heart. Schüssler calls *magnesia phosphorica* a great nerve tonic, especially when the pains are relieved by warmth.

*Calcium*. What a Nihilist Professor Penzoldt is! Chalk is an antacid, or gypsum good for bandaging. Lime water added to cow's milk renders it more digestible for children and may benefit when diarrhoea prevails. Whether it dissolves diphtheritic membranes is more than doubtful. Its use in burns combined with linseed oil is antiquated. The carbonate of lime is a mere antacid, but useful in cases of poisoning with acids. For rachitis calcium phosphoricum is

praised, and if it does not help it can certainly do no harm. Its external use by injections into tuberculosis joints is vouched for by high authorities. With us, on the other hand, the lime salts stand only second in importance to sulphur, and in children's diseases it certainly with us takes first rank. Malassimilation by faulty nutrition everywhere, whether we call it psora or scrofula or tuberculosis, and in chlorosis of apparently healthy looking girls with their delayed evolution we find the lime salts are more often indicated than ferrum and its preparations. A weak, gone, distressed feeling pervades the whole nervous system when *calcareo phosphorica* is indicated; it is useful, furthermore, when too much work and too little sensible recreation causes the student's headache and nature craves eggs, plus the shell for its recuperation.

The use of the *alkalis* Penzoldt nearly limits to the application of the mineral waters according to their well-known indications in hepatic and urinary complaints. How much the old school might learn from the mineral doses of salts which these springs contain. The artificial waters from the chemist's laboratory fail to have as good an effect as nature's free offering. Who would treat a case of phthisis without interpolating, when necessary, a dose of *kali carbonicum*? While it simulates iron in the false plethora of anæmic dyscrasic patients with its exhausted nerve force and weakened heart, the sour eructations, the heart-burn and the uneasy, nervous feeling when hungry show that the patient is run down and wants building up.

Of the salts of soda Penzoldt only mentions salt as the chief representative. Physiologically it is considered by him as a stimulant and tonic, whatever that means; but with us it is more, strengthening the nutrition of the whole body, and it is often in qualitative what china is for quantitative anæmia. When quinine was scarce old physicians cured their malarious cases with solutions of salt, and with us, it remains, when indicated, a standard remedy in this disease. Still, we often prefer *natrum sulphuricum* when the chilly hydrogenoid constitution stares us in the face; and Schüssler's *natrum phosphoricum*, the Pittsburgh *natrum arsenicosum* and our old *natrum carbonicum* might even convince an old-school practitioner that great differences exist in the application of the different salts of sodium. Verily, where is their individualization in drug action? Penzoldt thinks *ammonium carbonicum* may be dispensed with and that even the use of *ammonium chloride* is now a rarity, though some use it still in inhalations and vapors to loosen the tough phlegm in

chronic bronchitis and catarrhal pneumonia of children he acknowledges to have witnessed some benefit. We feel more than astonished at these statements, for the carbonate of ammonia remains to-day as of yore our sheet-anchor in all adynamic cases, with degeneration of the blood as we see too often in malignant eruptions and in typhoids, or in that fatal cerebro-spinal meningitis which ought to be rather known as spotted fever. In lithæmic cases the muriate and phosphate of ammonium are even too much neglected by our own school, and it is a pity that so many look for new drugs and thus neglect old and tried friends. Years ago, before light beamed on me, the salts of ammonia were considered of the greatest importance, and many serious catarrhal troubles yielded readily to a solution of the muriate, plus a little extract of hyoscyamus.

*Arsenicum* cannot be compared with quinine in intermittent fever, and in old cases or where the malarial cachexia prevails, it certainly does good. It is of undoubted efficacy in psoriasis and eczema but it must be employed energetically (in gradually increasing doses from 2—12 milligrammes daily) and for a long time. Internally and by parenchymatous injection it gave relief in some cases of malignant lymphoma and failed in others. No benefit is to be derived from it in leucæmia, pernicious anæmia, chlorosis or tuberculosis. It may perhaps do some good in rachitis and osteomalacia. In malarial neuralgia and in chorea minor some have witnessed benefit. Direct contraindications are all disturbances of digestion, hence in cachectic states, where nutrition is of the utmost importance.

On the contrary, to us, inflammation of the stomach and bowels primarily and next those of the heart, are chief indications and in Asiatic cholera the arsenious acid achieved its greatest triumph. How often does the same drug change the unfavorable aspect in typhoid and miasmatic fevers, and insure recovery in doubtful cases. The same adynamia may prevail in diphtheria. Here arsenic becomes a valuable aid, should the other symptoms correspond and the same thing may happen in any eruptive fever. Malignancy may be one keynote for its employment, though it may be used with equal benefit in functional neurosis and early applied in the higher potencies is perfectly able to prevent the consecutive organic disease. No indications from the old school when quinine, when arsenicum or when natrum muriaticum is to be employed! Why will they never learn to individualize the drug?

*Antimonium.*—*Antimonium tart.* is an emetic and causes pustules on the external and internal skin. As an emetic it is rather danger-

ous on account of the collapse which follows, and there are more suitable drugs to remove the tough phlegm in bronchitis. In pneumonia some recommend it during the first days of the disease in robust persons. All other antimonial preparations, even *sulphur auratus*, can be dispensed with.

The mapped tongue, the peevish mental state, the overloaded stomach! Who of us does not think immediately of antimonium crudum, while weakness of the heart and lungs, inability to raise the phlegm, Penzoldt's teachings to the contrary, are our indications for antimonium tart., hence it is only useful in a late and too often neglected case. In bilious pneumonia and in that of drunkards it has no equal.

*Phosphorus* is recommended in rachitis and osteomalacia, but even there its benefit is doubtful, except very small doses (0.0005 daily for a child) are prescribed. Hydrochloric acid can well be substituted for the phosphoric acid.

Well, I (S. L.) cured several cases of typhoid fever with its apathy with weak phosphoric acid lemonade, which prevented serious complications. Home, sweet home, may as often call for this acid, as for ignatia or staphisagria and how easily it is to individualize this nostalgia or any other grief. Polyuria yields often to it and how totally different its action from muriatic acid and still a Penzoldt says, it can take its place. Poor allopathy!

Irritable weakness is the keynote for the employment of phosphorus and Kapkassen calls it the great tonic of the heart; vital force runs at a low ebb, the back gives out, the limbs tremble and totter and in the now fashionable neurasthenia the prescriber will often look to it for aid. In softening of the brain it won many laurels. How many cases of fatty degeneration it ameliorates, though it does not cure. Penzoldt knows this from the many recorded cases of poisoning; and as it is one of the few remedies which act on the pancreas we understand its beneficial action in diabetes mellitus or morbus Brightii. I might still mention its frequent employment in diseases of the respiratory organs, and could not exhaust it in a few lines, when Sorge wrote a book about it.

The therapeutic use of *sulphur* is of very little importance. As a laxative it is superfluous and in cutaneous affections the naphthol preparations take its place. Sulphur-springs, hot or cold, keep up their old reputation. The mixturæ sulphurica acidæ may be omitted now-a-

days, for muriatic acid corresponds to all indications and even for disinfection sulphur preparations have given place to better methods.

With us sulphur becomes the centre-board of our materia medica and whenever there is a hitch in the treatment, the interpolation of a dose of that drug may be required to bring about reaction. Impurity outside and impurity inside is the keynote of sulphur, and hence its applicability in chronic as well as in acute diseases. It is a wonderful drug and still how different from the nasty psorinum, which raised many a marasmic child from the grave. Sulphur of very little importance! The ancients knew better and we witness to-day in old-school therapeutics too much progress backwards.

*"Kalium silicicum and natrum silicicum are in use as bandages, to render them immobile."*

Oh! How I feel like whistling, in order not to be profane! How our silicea proves the power of potentization and how it liberates giants lying inert on the crude substance.\* Wherever connective tissue tends to chronic suppuration, silicea will be in place. Sycotic scrofulosis finds in it a drug of high order, and in the nervous system, we meet paresis from defective nutrition of the nerves. Heredity and silicea go hand in hand, but what does an allopathic professor know about antipsorics.

(To be continued.)

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#### TWENTY-SIXTH ANNUAL SESSION OF THE HOMŒOPATHIC MEDICAL SOCIETY OF THE STATE OF PENNSYLVANIA.

THE Twenty-sixth Annual Session of the Homœopathic Medical Society of the State of Pennsylvania was opened at the Hahnemann Medical College, Philadelphia, on September 17th, by an address of welcome delivered by Dr. Augustus Korndörfer in behalf of the Philadelphia County Society, and to which response was made by Dr. C. F. Bingaman, President of the State Society. Dr. C. S. Middleton, First Vice-President, then took the chair, while the President delivered his annual address.

In this address he spoke of the advance of homœopathy during the past year, saying that at "no time since medicine became a

science has it made such rapid strides," and referred to the number of new colleges that have been recently erected.

He enlarged upon the subject of the proposed "Medical Examiners' Bill," and said that it ought to be considered one of the most important matters to come before the convention, and urged upon the members the necessity of being ready to guard the interests of homœopathsists in this connection.

Dr. Bingaman expressed gratification at the action of the American Institute in changing the course of study from four to five years after the session of 1891-92, believing that the results would be highly beneficial.

In speaking of the insane of the Commonwealth, the President proceeded to show by figures that the percentage of cures had been greater under the "new-school" method of treatment than under the "old," and urged the necessity for larger facilities for caring for these unfortunates. He could see no reason why the homœopathsists should not have a state asylum under their care, as is the case in New York State.

The Treasurer's report showed there was still a large deficit arising from the publication of the repertory, and that of the Corresponding Secretary and of the Publication Committee that three hundred and fifty volumes of the *Transactions* of the Society had been published and distributed.

Dr. Pemberton Dudley, for the delegates to the meeting of the American Institute of Homœopathy last June, reported a successful session and an increase of membership, and of the selection of Atlantic City as the next place of meeting, in connection with the fourth Quinquennial International Congress of Homœopathy.

The necrologist, Dr. W. J. Martin, reported the deaths of Drs. L. B. Hawley, W. B. Trites, John Malin and Thomas Nichol.

The report of the Bureau of *Materia Medica* was then presented by the chairman, Dr. C. S. Middleton, who said that the work of compiling the repertory had grown very unpopular with those engaged in it; and that notwithstanding his most strenuous efforts, he had only secured the completion of three more sections as follows: Repertory of Sensations, by Dr. S. F. Shannon, of Denver, Col.; Repertory of Face Symptoms, by Dr. A. A. Norris; and Repertory of Cough Symptoms, by Dr. C. S. Middleton. He then called upon Dr. Mohr, who read a paper entitled "Beliefs Concerning *Materia Medica*."

The essayist called attention to the fact that for a number of years past many had wondered why so little had been done for the improvement of the distinctive branch of our school. But few provings have



been made. The contributions of materia medica papers are few and far between. At society meetings, materia medica bureau reports are notably the most meagre. Efforts to discredit our materia medica have not been wanting, and there have been quite persistent attempts made at critical revision and condensation which, if carried to the extent some would have us do, would make of our materia medica a disarticulated skeleton. He did not deny that our works on materia medica contained faults, and he expressed himself in favor of revision, analysis and condensation. Much of the indifference to materia medica he thought due to the difficulty required in keeping pace with the collateral branches of medicine. He thought that the remedy lay in a more thorough education of students, rendered possible by the adoption of a compulsory three years', and optional four years', course. The student's first year should embrace medical botany; the recognition of vegetable, animal and mineral drug substances in their crude forms; the methods required to convert these into active medicinal forms; a consideration of the general effects on the healthy of material and toxic doses of the most commonly used medicines; how drugs are classified according to effects by old-school therapeutists; how drugs are administered, and what are the maximum and minimum doses. The second year should embrace medical chemistry, toxicology, method of proving medicinal substances; an explanation of pathogenetic effects according to the known laws of physiology, the pathogenesis being presented, as far as possible, in narrative form. During the third year an analytical study of drug phenomena should be pursued, for which the student has been prepared by his previous training in anatomy and physiology; the pathogeneses of the drugs classified in natural orders and groups according to the respective rubrics. Under each rubric should be considered the various concomitant symptoms. A fourth year should be devoted to a consideration of the application of drugs—antipathic, allopathic and empyric,—the greatest care being exercised to teach the homœopathic application. He should be taught to prescribe according to the totality of the symptoms, and not according to the name of disease. At the end of each year an examination should be held.

In opening the discussion, DR. AUG. KORNDORFER said he doubted if it was a wise course to devote as much time to physiological materia medica, as advocated by Dr. Mohr, to the exclusion of the symptomatological. Many symptoms cannot be classified according to their physiological relations. Many of the pathological conditions which we think we understand to-day, we find ourselves ignorant of to-morrow. If the studies of physiological action of drugs are so conducted as to make prominent the peculiar characteristics of the same according to the Hahnemannian doctrine, as obtained from provings, then we have attained the highest type of instruction. Students should learn the effects of the crude drug that

they may antidote them. They should learn also the genius of drugs. This is best gotten by first obtaining the physiological action, and the superstructure is built by a thorough knowledge of the symptomatology. Any system which belittles symptomatology brings about the deterioration of the ability as a prescriber of the party so studying. For years there has been a cry of "tares." For years the speaker had been waiting for the harvest. In the meanwhile, he had been harvesting for himself, and he thought this was the plan all should follow; but, at the same time, we should lay up a store for others.

DR. MOHR believed that the teaching of characteristics could be pursued more profitably during the second than the first year. If the so-called key-notes are taught students at first, they become negligent of the other points. They think when they have learned the key-notes, that they have acquired a knowledge of the drug.

DR. M. S. WILLIAMSON thought that it would be a good thing if students were not taught a single symptom until they were well grounded in the collateral branches. They must know something of the action of crude substances. Diagnosis should certainly precede the study of materia medica, for then only can we know the value of symptoms. After the student has acquired a knowledge of the effects of crude doses, then he can take one more step.

DR. KORNDÖRFER said that Boenninghausen made many cures, and yet his knowledge of diagnostics and pathology was not up to that of the present day; the same was true of Jahr, Hahnemann, and Hering, and yet no one dare stand here and say that they know more of materia medica than those old men who knew so little of the pathology that we know to-day. These studies are necessary to our students, but they should be regarded as collateral. Are mistakes in diagnosis made more frequently by homœopaths than allopaths? It was the speaker's experience that great mistakes were made by the so-called great pathologists of the old school. Men well versed in the study of symptomatology are far better fitted as diagnosticians than are the men educated in the physiological school of to-day.

DR. PEMBERTON DUDLEY said that pathology had its uses and abuses. He was a strong believer in the value of pathology, but he did not approve of pathology being made a basis for prescribing. The correct use of pathology to the homœopathist is, that it enables him to get the totality of the symptoms. The very fact that we are better pathologists to-day enables us to get a better totality than could be obtained in Hahnemann's day, and so making us better

homœopathists. As to diagnosis, the mere name of a disease covers but a few cases. The same remarks that have been made respecting the genius of drugs, applies to the genius of the cases.

DR. CHARLES MOHR said that he used the term physiology in the sense given by Dr. Dunham, namely, sick physiology. He thought that we must appreciate not only the anatomical lesions, but also every deviation from the normal standard of health.

DR. A. P. BOWIE did not think that the members of this society knew as much as Hahnemann did; for Hahnemann had a far better idea of materia medica, based on his knowledge of drug proving. If we worked with one-tenth of Hahnemann's zeal, we would hear less talk of the imperfections in the materia medica.

DR. DUDLEY said if his remarks were offensive he would withdraw them.

**AFTERNOON SESSION.**—The Bureau of Clinical Medicine reported through its chairman, Dr. E. C. Parsons, of Meadville. After a few remarks by the chairman, Dr. Clarence Bartlett read a paper on "The Diagnosis of Abscess of the Brain, considered with Special Reference to the Question of Treatment."

In response to a call from the President, DR. W. B. VAN LENNEP said that he had had two cases of abscess of the brain, both of them in association with Dr. Bartlett. He emphasized the importance of brain symptoms coming on late after an injury as diagnostic of cerebral suppuration. He also called attention to a fact not referred to by the author of the paper, that these abscesses not infrequently had very thick and tough walls, as he found in one of the cases in which the toughness was so great as to lead him to mistake the abscess wall for the tentorium. In another case he should feel justified in using greater force in attempting to puncture the abscess walls with the grooved director.

DR. G. MAXWELL CHRISTINE read "A Case of Remittent Fever, with Hæmorrhagic Complications and Remarks concerning the Differential Diagnosis of Remittent and Enteric Fevers." (This paper will appear in full hereafter.)

DR. W. C. GOODNO said that those who attempted to make a diagnosis of typhoid fever by the temperature curve alone would meet with disappointment. In this country, at least, we rarely meet with the typical so-called typhoid fever curve. Many cases begin with an intermittent fever and pass on to the remittent form, and finally an almost continuous fever. Sometimes the fever begins in a typical

way and then presents these changes towards the close. The enlarged spleen and the characteristic eruption on the abdomen are important diagnostic points. In cases of doubt the microscope may be appealed to. In typhoid fever the special bacilli will be found in the stool, and in remittent fever hæmatin crystals will be found in the blood.

DR. W. G. DIETZ described a case in which he was in doubt as to whether it was a case of typhoid fever or tuberculosis. The symptoms given in detail were of a severe type, and could indicate either of the above-named affections. Finally, the typical rash appeared on the abdomen. The spleen was enlarged. Cinchona was given because of the profuse sweats, the diarrhœa, and the extreme prostration, and it effected a prompt cure.

DR. G. M. CHRISTINE said that he had submitted enough samples of blood and fæces to competent microscopists for examination to make him feel very doubtful of any diagnosis made by them. The hæmorrhages in remittent fever he believed to be due to congestions of the mucous membranes. He did not believe that we could always diagnose typhoid fever by the temperature curve, but he did not think that after an intermittent had lasted for a week that we could have typhoid fever as a sequence. If we find distinct remissions, we should be very doubtful of our diagnosis of typhoid, and, other things being equal, make a diagnosis of typhoid fever. When we have an array of symptoms differing in so many essentials from typhoid or so-called typho-malarial fever, we should, in the speaker's opinion, make a diagnosis of remittent fever.

DR. GOODNO said that he had not pretended to make a diagnosis in the essayist's case. He believed, however, that it was well established that typhoid fever had its special bacillus. In protracted cases of malarial fever there is decomposition of the blood. The coloring matter is separated and accumulates in the capillaries, and as a result of the obstruction to the circulation the hæmorrhages occur, and not as a result of a special congestion. He did not think it possible to make a diagnosis in every case by the microscope, yet that instrument should be called into play in cases of doubt.

DR. CHANDLER WEAVER reported a case of epithelioma of the fauces cured by local and internal medication. The history of the case was clear, and a microscopic examination made by eminent old-school microscopists confirmed the diagnosis made by equally eminent laryngologists. The case had been treated by the previous attendants by the local application of cocaine and the internal administration of morphia. Dr. Weaver's treatment consisted of the internal

administration of arsenicum 3x and the application of the 4x to the parts. Improvement began and continued for a time, when the remedy was changed to calendula both locally and internally. The cure of the case was complete. A syphilitic factor in the case was eliminated.

DR. W. C. GOODNO said that it was certain that the vast majority of cases of malignant disease do not get well. The few that do recover we look upon with suspicion. We could not be positive that Dr. Weaver's case was one of epithelioma, though he would not detract from the brilliant cure. The fact remained that the characteristics of many of these superficial ulcerations are exactly the same as those of epithelioma.

DR. WEAVER, in reply to the question by Dr. T. J. Gramm, said that there was no glandular involvement.

DR. W. B. VAN LENNEP, following out the line of thought suggested by Dr. Goodno's remarks, said that he had treated a case of ulceration of the lip, in which the clinical characteristics of epithelioma were all present. A history of probable syphilis was obtained. In three weeks' time that so-called cancer was healed entirely under the internal administration of iodide of potassium. He thought that Dr. Weaver had made a most brilliant cure, but he would not like to have deduced from the case generalizations leading to the general treatment of cancers by remedies until such extensive infiltration has taken place as to carry the case beyond the use of the knife.

DR. JOS. E. JONES reported a case of strangulated hernia cured without operation.

The patient was a boy five years of age. When called to the case Dr. Jones found the boy resting on a lounge which had a high arm or end to it. He had the patient turned around and his limbs drawn up and over the arm of the lounge until his body was at an incline of at least forty-five degrees. A cloth saturated with a mixture of three-fourths ether and one-fourth arnica was then placed over the tumor. From time to time gentle pressure with rubbing in a direction to remove from the hernia any liquid or gas that might be confined there, was performed. Finally, nearly twenty-four hours after the violent symptoms of strangulation set in, the gut returned to the abdominal cavity with a loud gurgle.

DR. E. C. PARSONS said that he had had a similar case, in which reduction was accomplished by pressure aided by warm applications.

DR. W. G. DIETZ read a paper on "*Alstonia Constricta*." (This

paper will be published in full.) It was followed immediately by a report, by Dr. W. J. Martin, of a case of abscess of the lung and a number of other cases.

Dr. DIETZ opened the discussion on Dr. Martin's paper by remarking that the author had omitted to mention *rhux tox.*, which is a very important remedy when the uvula has the appearance of a little sac of water. The three main remedies in diphtheria, in his opinion, were *lycopodium*, *lachesis* and *lac caninum*. *Lachesis* was especially valuable in cases beginning on the left side, *lycopodium* when the right side was involved. *Lachesis* is furthermore indicated when the pain in the throat is out of all proportion to the objective symptoms. In cases of defective reaction following acute diseases he recommended *castoreum*, especially when night sweats are present.

Dr. C. VAN ARTSDALEN read a paper on "Whooping Cough." The symptomatology, diagnosis and treatment of the affection was carefully described, and a number of illustrative cases were reported. The society then adjourned until evening.

EVENING SESSION.—Dr. E. R. Snader read a paper on "Stoop and Round Shoulders: Their relation to Chest Expansion and Phthisis Pulmonalis;" Dr. Charles Mohr, one on "Cases of Goitre," and Dr. W. W. Van Baun, one on "The Treatment of Paroxysmal Heart Hurry."

Dr. TRIMBLE PRATT, in confirmation of Dr. Mohr's remarks regarding the association between thyroid enlargement and disease of the reproductive organs, cited one case in which, by treating large cystic tumors of both ovaries, the thyroid enlargement was rapidly removed.

Dr. W. G. DIETZ called attention to the well-known fact that extirpation of the thyroid was followed by a cachexia which ended in death. He agreed with Dr. Mohr that we should treat our patients, and not names of diseases.

Dr. CHARLES MOHR, discussing Dr. Snader's paper, agreed that if we made efforts looking toward the correction of the deformity by proper exercise, we would note a decided lessening of the number of phthisical cases. He had seen cases with a decided family history of phthisis improve rapidly under breathing exercises, consisting of forcible expansion of the lungs from three to five times a day. He generally recommended the exercises be performed while the patient was walking along the street, or ascending a flight of stairs. He

only advised one forcible respiration the first day, to avoid tiring the patient. The number was gradually increased until the full allowance of exercise was reached. Many of the cures following the oxygen treatment are the result of the breathing exercise required, though he was free to admit that oxygen of itself, when properly administered, would do good.

DR. AUG. KORNDORFER agreed with both Drs. Snader and Mohr regarding the value of breathing exercises. His plan was that suggested by Dr. Jackson, many years ago. He suggested that three or four times daily, fasting or just before meals, the patient should take one deep inhalation, first having exhaled as freely as possible, filling the lungs slowly through the nostrils. Then the air is slowly exhaled through a quill. This method has the advantage of retaining the air in the lungs, and brings about a considerable muscular exertion from below, thus forcing the air into the minute air-cells. The patient should be cautioned not to indulge in the exercise any oftener than directed by the physician, as he had known harm to come from the excessive exertion.

DR. E. H. VAN DEUSEN, discussing Dr. Van Baun's paper, said that two cases of rapid heart had come to his notice. One case was that of a lady, aged 32 years, four months gone in pregnancy. She seemed to be suffering severely, and she thought that she would die. Her face bore an anxious expression, and she complained of a thrilling sensation in the neighborhood of the heart. She had had previous attacks of palpitation, but none that had been severe. He gave her aconite, and applied cold over the heart. Recovery was prompt. He had examined her since, and failed to find any murmur. Her pregnancy has progressed favorably. The other case was that of a boy, aged 15 years. The attacks of rapid heart would come on him while in the street, without any warning whatever, and were accompanied by a sensation as of a thrill in the cardiac region. Under ordinary circumstances, his pulse was from 80 to 90 per minute, but during the attacks it was uncountable. He had, at irregular intervals, sharp, stitching pains in the region of the heart, and for these he was given spigelia, which seemed to control the rapid heart also.

DR. W. G. DIETZ reported a case of rapid heart action in a friend. The attacks were not attended by anxiety. The patient had been subject to the attacks for years. He was otherwise in perfect health.

A paper by Dr. Joseph Rodes, of San Diego, California, was read by title.

The last communication was "Post-febrile, Diphtheritic and Infantile Paralyzes," with an illustrative case of each, by Dr. E. C. Parsons. This paper gave a careful review of the predisposing causes of paralyzes, stating the same to be utter disregard of all hygienic rules governing dress, respiration, sexual habits, etc., and closed with a report of three cases, as indicated in the title.

The Bureau of Pathology next reported. A paper, entitled the "Pathology of Chronic Alcoholism," by Dr. W. K. Ingersoll, was read by title, and referred for publication.

Dr. W. B. Van Lennep, Chairman of the Bureau of Surgery, then presented the report of the Bureau. The papers by Drs. L. H. Willard, on "Probing in Wounds," and by Dr. J. H. Thompson, on "Protrusions from the Abdominal Cavity," were read by title, as was also the paper by Dr. Charles M. Thomas, reporting forty-one cases of operation for stone in the bladder, with exhibitions of specimens. The specimens carefully mounted, were presented to the Society for inspection by Dr. Van Lennep. Dr. Carl Vischer was then called upon to read his paper on the "Pathology of Prostatic Diseases." It was discussed by DR. VAN LENNEP, who said that hardly a month passed by in which he was not called upon to relieve a retention of urine due to prostatic disease. The difficulty in most cases he found to be that the physician had used improper instruments, usually a metallic or an English catheter with stilet. If the Mercier catheter had been used, there would have been no trouble in most cases. This catheter should be passed down, with its beak looking upwards, in which case it will ride very readily over the obstruction. The enlarged mouths of the ducts can usually be avoided by using as large a catheter as possible. In cases that will not yield to the Mercier catheter, we may resort to a device of Ultzmann. Use an English catheter with a hyper-curve; then pull on the stilet as it rides into the bladder. Still another point is, that one hears much of the effects of self-abuse. Now, the speaker believed that self-abuse, as a cause of prostatic disease, sank into insignificance, in comparison with gonorrhoea. He thought, therefore, that physicians should never, under any circumstances, take it upon themselves to advise illicit intercourse as a remedy for any ailment, real or fancied.

Dr. J. William Giles next read a paper on "Flat-foot."

The author carefully detailed the symptoms and effects of this deformity. He spoke of instances in which this affection had been mistaken for rheumatism and inflammatory conditions of the tarsal



and metatarsal joints and ligaments. All cases suffering from pain at the inner ankle should be examined with a view to the detection of this deformity. In the treatment of the milder forms, he advised the cultivation of a proper walk, *i.e.*, with little or no outward divergence of the toes, the application of proper shoes and certain foot-gymnastic exercises which tend to develop and strengthen the muscles, such as walking on tip-toes, and on the outer margin of the foot. Massage and electricity are useful adjuncts. Where the deformity has extended to dislocation, then reduction under anæsthesia is necessary. The foot should then be retained in a position of varus by some fixed dressing. He then exhibited an apparatus devised by Gefvert, which he had used with very satisfactory results.

DR. W. B. VAN LENNEP then reported a number of cases of abdominal section. Owing to the lateness of the hour, discussion was postponed until the following morning.

## SECOND DAY.

MORNING SESSION.—DR. T. J. GRAMM referred to the case of hysterectomy as one that had particularly interested him. He reviewed the different methods of treating the stump and considered its extra-peritoneal treatment as unsurgical on account of the sloughing that follows. The intra-peritoneal method was the more surgical. He described a case of intra-ligamentary cyst he had operated, with a very successful result.

In answer to a question regarding the relative value of lumbar and inguinal colotomy, DR. W. B. VAN LENNEP said that, in a certain number of cases, the descending colon and, in a smaller number, the ascending colon have a complete meso-colon, so that they cannot be reached through the connective-tissue at all. Then, the abdominal cavity has to be opened. In the lumbar operation, we are hampered in our manipulations by the depth of the wound and the narrow space between the ribs and the ileum. It has happened, in the experience of operators trying lumbo-colotomy, not to find the colon at all. Some of them have even opened the duodenum by mistake. On the other hand, many of the younger English surgeons of note, many American and most German operators advocate inguinal colotomy as the preferable operation. He, himself, had been surprised, in the case under discussion, at the ease with which the colon was recognized and drawn out. The patient was practically moribund at the time of operation. Therefore, cocaine was used locally with a few whiffs of chloroform. After

the incision, the first loop presenting was the sigmoid flexure which was readily recognized by its longitudinal fibres, sacculation and the appendices epiploicæ.

The great trouble with artificial ani, especially when they are to be permanent is that we have more or less retraction of the spur, so that fæces not infrequently pass into the lower diseased portion. The idea advocated by Maydl prevents this, although the same object can be attained by passing a stitch through the abdominal walls and under the intestinal loop. The spur, however, is not so marked.

He agreed with Dr. Gramm that the method of treating the stump by bringing it into the abdominal wound was not a surgical one, but it was by far the safest. The ideal one would be to ligate the uterine and ovarian arteries and make a complete extirpation of the uterus and ovaries, leaving nothing behind to slough. The method of treating the stump to which Dr. Gramm referred as Kelly's, the speaker had done two years ago. At the time he thought he was doing Schröder's method.

The objection that he had to this plan is that there must necessarily be sloughing. After the elastic ligature is loosened, between every stitch, blood will gush out and interrupted sutures must be applied to arrest it. Necessarily, with these seventy-five or a hundred stitches, there must be some sloughing of tissue. He should never, under these circumstances, feel justified in dropping the stump back. Besides, the mortality statistics were strongly against it. Of the other cases, he desired to refer to that of appendical abscess. He did not think that the abscess should have been opened at once into an intact abdominal cavity even had he been sure that it would empty into the bowel. As is well known these abscesses have a most horrible stench. Fallopian abscesses are not to be compared with them in the danger of infection. Even evacuation and thorough disinfection he did not consider would have been safe. In all of these cases where the wound is left open, there is danger of subsequent hernia.

This closed the report of the Bureau of Surgery.

The Bureau of Obstetrics was then called for. Dr. E. H. Van Deusen reported a case of monstrosity by defect.

While a number of minor abnormalities existed, the main defect was an entire absence of the abdominal walls and diaphragm. The intestines were probably held in situ during uterine life by the parietal peritonæum. The ribs on the right side were bent acutely upwards at a line drawn from the ensiform cartilage to the angle of

the scapula, and exposing the heart which was observed to beat for a few minutes after birth. The pleura and peritonæum were continuous. The liver was a large and shapeless mass and there was no suspensory ligament. From the stomach there ran a large gut resembling the colon and increasing in size until about at the jejunum, when it suddenly diminished and continued uniform in diameter to the cæcum and appendix vermiformis. From the cæcum to the anus was a distance of about five inches. This portion of the intestinal tract was smaller than any other portion.

DR. YOCUM also reported a case of deformity. The absence of the cervical vertebra gave the child a leonine appearance. The mother, it was alleged, had been frightened during her pregnancy by a lion at a menagerie.

Dr. Gerhart's paper reporting a case of puerperal convulsions, cured by belladonna 200, was read by title as the author was absent and had not then sent in his paper.

DR. W. J. MARTIN reported a difficult case of labor in which a defect in the obstetric forceps as manufactured by the makers, was strikingly manifest.

The case was one of difficult labor in which the difficulty arose, it was afterwards learned, from the very large size of the child. Forceps being necessary the ordinary Hodge instruments were applied, but slipped off, notwithstanding numerous trials. Dr. C. P. Seip was sent for in consultation, and he brought with him a pair of forceps with long and narrow blades that had been made for Dr. H. H. Hofmann many years ago by a Pittsburgh blacksmith. These were readily applied, and with them delivery was effected. They did not slip. The essayist then exhibited the ordinary Hodge forceps and compared them with Dr. Seip's instrument, showing the shortness of the blades of the former.

DR. W. G. DIETZ said that he had a case similar to the one reported by Dr. Martin, several years ago. He applied the forceps, but as soon as he made strong traction the instruments slipped. He reapplied the instruments twice but with the same result. He then sent for consultation ; an allopathic physician who responded met with the same luck. They then decided on version, and after a hard pull they succeeded in effecting delivery. The child weighed seventeen and a-half pounds and was still born. The question had arisen in his mind regarding the propriety of performing version in these cases in the first place without first attempting to apply the forceps. After performing this operation you have the narrow part of the child coming first. While the life of the child is probably

endangered, the mother whose safety we must look after above all things, has far better chances.

DR. W. J. MARTIN differed from Dr. Dietz regarding the propriety of version. He thought that operation would make matters much worse.

DR. T. J. GRAMM thought that when delivery became so difficult as to require the exertion on the part of the accoucheur, as described in the paper, the question of Cæsarian section should be entertained. It is a comparatively safe operation if performed before the vital forces of the patient are exhausted by long waiting.

DR. C. P. SEIP said in answer to a question by Dr. T. M. Johnson, that he had not seen a pair of forceps that could be applied as readily as those exhibited by Dr. Martin. When once they get a hold on the head of the child there is no letting go; something is bound to come.

Dr. Sarah J. Coe read a paper entitled "The Value of Medicines in Pelvic Diseases before resorting to Surgery." This paper contained the report of several cases of urethral caruncle treated without resort to operation. Case I. was attended by considerable hæmorrhage. It was cured by hamamelis fluid extract locally, and hamamelis 3x internally. Case II. was given sulphur 200 on account of pruritus, and hamamelis fluid extract was applied locally. Cure was prompt. Similar growths in the rectum do not respond so readily to treatment. The author reported two cases, however, in which her treatment yielded good results.

Dr. Millie J. Chapman read some reported "Clinical Cases."

The first two cases were ones of premature menopause. The remedies recommended by the author for climacteric conditions were lachesis, when flashes of heat are followed by coldness; sulphur, if the heat is followed by profuse perspiration; *actea racemosa* if the flashes of heat are associated with mental depression as if a cloud settled down over the patient; distressed and suspicious without apparent cause. The third case reported was one of dysmenorrhœa with numerous complications, one of which was tape-worm.

DR. W. J. MARTIN said that he had used turpentine successfully in the treatment of tape-worm. A large dose of the drug was beaten up with the white of egg, and after that castor-oil was given.

DR. B. F. BETTS thought that the use of large doses of turpentine was dangerous. He had used *felix mas* and had followed with small doses of turpentine with good results.

DR. MARTIN said that the large dose he administered (2 oz.), produced considerable warmth in the stomach, but no other unpleasantness.

DR. SARAH J. COE reported a case which she had successfully treated by two ounces of kousso followed by a dose of castor-oil, and later, pelleterine.

DR. W. G. DIETZ called attention to a well-known domestic remedy for tape-worm, namely, pumpkin-seed.

DR. C. P. SEIP reported a case coming under his care, in which a patient was passing shreds of mucous membrane under the supposition that they were pieces of tape-worm. He had been taking turpentine and his physician had ordered larger and larger doses to expel the worm. Dysuria was present at first.

DR. E. S. SHARPLESS said that he had treated several cases of tape-worm successfully by the administration of *felix max* and *rot-tilerae*. He had also used pelleterine successfully.

DR. W. G. DIETZ called attention to the fact that a writer in the *Therapeutic Gazette* had advised large doses of chloroform for the removal of tape-worm. He himself had no experience with this method of treatment.

DR. J. S. BOYD said that the reason why many remedies used for the removal of tape-worms failed was the want of a preliminary cathartic. There is always a quantity of mucus in the intestinal tract and this not infrequently protects the parasite from the effects of the poison.

DR. C. H. HOFMANN's paper on "Three Cases of Laparotomy" was read by Dr. Millie J. Chapman.

DR. MARY BRANSON then read a paper on the medicinal treatment of uterine fibroids.

DR. T. J. GRAMM thought that there was too great a tendency on the part of physicians to treat fibroids and other conditions requiring surgical attention, by medicine alone, until the case had progressed so far as to make all surgical interference hopeless.

DR. B. F. BETTS thought that the question of operation was one which should always be decided with great deliberation. One rule is always a good one, namely, to operate when the patient is in the best condition possible. Efforts should be made to improve the patient's condition with medicine as far as possible. We do not lose ground by deferring operation and trying homœopathic treatment.

Dr. ISAAC G. SMEDLEY then read a paper on "The Treatment of Face Presentations."

This paper was discussed by Drs. Dietz, Smedley and Boyd, when the Society adjourned until afternoon.

**AFTERNOON SESSION.**—The Bureau of Ophthalmology, Otolaryngology reported. Dr. H. K. Hoy acted as Chairman in the absence of Dr. R. W. McClelland.

Dr. BIGLER read a paper entitled "An Enigmatical Case," in which was reported a case of what was apparently an organic brain disease with severe eye symptoms, but which made a most excellent recovery.

Dr. HOY next read his own paper on "Aural Practice." This paper consisted of a review of a number of small points in the treatment of aural disorders. Its nature was such that a condensation was impossible. These facts were so tersely stated that an abstract of it was impossible.

Dr. W. H. BIGLER, in discussing Dr. Hoy's paper said that he preferred the dry method of cleansing the ear whenever it was possible to employ it. In many cases, the hardened wax can be removed in a solid lump. The syringe leaves the parts in a soaked condition. The dry treatment of middle ear suppuration he thought preferable to the wet. Where, in a chronic case, there is perforation of the membrana tympani, he would prefer that it not heal, as the hearing is generally better while the opening persists.

Dr. W. W. SPEAKMAN then read a lengthy paper on "The Eye in Relation to General Diseases." This paper consisted of a review of the eye symptoms of a large number of systemic diseases, together with a consideration of certain constitutional affections on the eye structure itself. The paper was an extremely valuable one. An abstract could not be prepared as the paper consisted of a condensed consideration of a large number of facts.

A paper by Dr. John C. Morgan on "Three Cases of Glaucoma" was read by title and referred for publication.

Dr. ISAAC G. SHALLCROSS read a paper on "Tubercular Laryngitis."

Dr. C. P. SEIP, discussing the last-named communication, said that he once thought that he had cured a case of tubercular laryngitis, but soon discovered his mistake. He applied lactic acid locally, as was recommended by Dr. Shallcross. Whenever a tubercle was touched with the acid it healed; but another one appeared. Finally,

he put the man on iodide of potassium, and within twenty-four hours there was a most remarkable improvement, which continued until the man was perfectly well. He thought it was a case of syphilis of the larynx.

DR. CLARENCE BARTLETT said, in response to a question by Dr. Dunning, that improvement under the iodide of potassium was not necessarily evidence of a syphilitic origin, though it indicated a specific cause very strongly. He quoted two cases from his own practice in which the iodide in large doses caused a most remarkable improvement in the symptoms where the pathological condition present consisted of sarcoma of the dura mater. Still, in the vast majority of instances in which the drug causes an improvement, a syphilitic cause is traceable.

DR. CHARLES G. RAUE, on being called upon by the President, was greeted with loud applause. He said that he would not like to say what the trouble was in Dr. Seip's case. He did not think that it mattered very much, for the patient was cured and that was the practical point. Kali hydriodicum has in its pathogenesis many of the symptoms described in Dr. Shallcross's paper. We should take the whole patient as he is when treating him, and not mind whether he is suffering from tubercular laryngitis, syphilitic laryngitis or some other trouble. In that way we would get the best results.

DR. H. F. IVINS thought that peroxide of hydrogen was a most useful agent for application in the treatment of tubercular laryngitis, especially in the stage of ulceration. So far as the relief of pain is concerned, the best thing is a spray of a ten per cent. solution of calendula.

Dr. Ivins then read his paper reporting a case cured by onosmodium. The Bureau then closed.

In the Bureau of Pædology, Dr. Duff's paper on "Catarrh in Childhood," was read by the Chairman, Dr. A. P. Bowie. Dr. Bowie presented a brief abstract of his own paper, after which the Society adjourned until the following morning.

In the evening, a banquet was tendered the visiting members and their friends by the physicians of Philadelphia.

### THIRD DAY.

MORNING SESSION.—The Bureau of Sanitary Science reported. The first paper read was by Dr. M. S. Williamson on the "Hygiene of the Alimentary Canal."

The author recommended as a means of preparing the stomach for the morning meal, that the patient take a drink of cold water on rising. For those suffering from catarrhal dyspepsia, warm water was preferable. In cases where there is loss of power of the stomach to act, especially when there is marked irritability, the action of hot water after eating is very soothing. Articles of diet should be forbidden, not because they antagonize medicines, but because they disagree with the patient. The author did not think it wise to lay down any hard and fast diet rules. Each patient must be carefully examined, and the diet best suited to his individual case prescribed. The author considered *in extenso* the question of diet of infants.

After the discussion of this paper, Dr. Cooper, of Allegheny, read a paper on "The Air We Breathe." This closed the report of bureaus, and the Society proceeded to transact general business. The report of the Committee on President's Address was received and accepted. The Committee on Medical Legislation reported. After a long discussion, its recommendations were adopted without amendment. (See *News and Advertiser*, current number.)

The Society then proceeded to the election of officers for the ensuing year, which resulted as follows:

President, Aug. Korndorfer, M.D., Philadelphia. First Vice-President, E. C. Parsons, M.D., Meadville. Second Vice-President, Millie J. Chapman, M.D., Pittsburgh. Treasurer, J. F. Cooper, M.D., Allegheny. Recording Secretary, J. Richey Horner, M.D., Allegheny. Corresponding Secretary, E. R. Snader, M.D., Philadelphia. Necrologist, W. J. Martin, M.D., Pittsburgh. Censors, Sarah J. Coe, M.D., Joseph E. Jones, M.D., and Clarence Bartlett, M.D.

The President then announced the committees for the ensuing year.

After selecting Pittsburgh as the place for the next annual meeting, the Society adjourned.

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ENURESIS NOCTURNA.—Tienhausen, of The Hague, believes that enuresis nocturna in children is caused (1) by insufficiency of the sphincter of the bladder which allows the urine to penetrate into the prostatic portion of the urethra, and (2) by reflex action of the circular fibres of the muscular walls of the bladder. Elevation of the pelvis prevents the urine from leaving the bladder, and thus obviates any necessity for irritation of the prostatic portion of the urethra. The child readily becomes accustomed to this position. The results following treatment by this posture are most excellent — *Semaine Médicale*, 36, 1890.



## EDITORIAL.

## THE OPHTHALMOLOGICAL SOCIETY AND HOMŒOPATHY.

THE report of the meeting of the Ophthalmological Society of the United Kingdom in the *Lancet* for July 19, 1890, contains the following apparently innocent announcement:

"An amendment proposed by Mr. Brudenell Carter and seconded by Mr. Frost, was lost, and the original motion carried."

Yet this simple little statement was the first news of what bid fair for awhile to develop into a first-class attack on homœopathy. In the *Lancet* for August 2d, Mr. Carter laid his grievances before the medical profession. He had tried hard, in the meantime, to suppress his outraged feelings, but when the few lines as above quoted appeared in print, he felt that he could "no longer maintain silence." He must give the profession the facts (?). It seems, *according to Mr. Carter*, that a patient consulted the surgeon at the London Homœopathic Hospital, but the ailment not yielding to treatment, the latter, who, by the way, was Mr. Knox Shaw, consulted an eminent allopathic ophthalmologist as to the management of the case and its diagnosis. The eminent allopath in question did not hesitate to meet Mr. Shaw in consultation, and (this is Mr. Carter's statement) accepted a fee for the consultation. Then, horror of horrors, he "sanctioned the return of the patient to the homœopathic hospital." Just to think of that! If he had only stolen the patient, he might have been forgiven! Mr. Carter goes on to say, that at said consultation further operative measures were condemned, and yet Mr. Shaw persisted in performing fresh operations; and that the patient was salivated from the constitutional effects of mercury. He then proceeded to tell just what he thought of the procedure. He says:

"The fact that a gentleman of the eminence of the consultant in this case submitted to meet a homœopath would be tantamount, in the estimation of many people, to a declaration that the consultant in question looks upon what is called homœopathy as a legitimate or defensible course of professional proceeding."

As Don Quixote sought feats of valor, and proceeded to demolish the wind-mill, so Mr. Carter rushed to the rescue of the honor of the

profession. He notified the secretaries of the society that he would, at the coming meeting, offer a resolution as follows :

"In the opinion of this society it is inexpedient and improper for its members to engage in professional consultations with avowed homœopaths, or with persons holding office in homœopathic institutions. The suggested resolution was so framed as expressly to exclude cases in which a consultant might meet a homœopath without knowing him to belong to the sect."

"Avowed homœopaths" is good. It would be all right, then, for Mr. Carter to meet in consultation a physician who practiced homœopathy (*a la* Ringer, Brunton, *et al*) but who gave his therapeutic practice some other name. The resolution, it may be readily seen, made it possible for the consultant to maintain the "honor of the profession" by neglecting to make inquiry as to the sectarian beliefs of any who might call on him for consultation.

In due course of time the announcements of the meeting were issued. Mr. Carter's motion was thus announced :

"A motion by Mr. Brudenell Carter as to consultations with homœopathic practitioners, with an expression of opinion on the subject by the Council."

Mr. Carter complains that the nature of his motion was not stated. Now, any one who knows that "gentleman" is fully aware of his opinions on the subject of homœopathy, and the mere mention of the fact that he had a motion to make concerning homœopathy is equivalent to an announcement of the exact character of that motion. The meeting was held. The motion was put, and, terrible to relate, no one supported it but Mr. Carter himself, and his assistant and literary co-laborer, Mr. Frost. Is it any wonder that Mr. C. wanted to resign?

The *Lancet* for August 2d comes out with four letters provoked by Mr. Carter's communication. The honorary secretaries of the Ophthalmological Society denied any intention to offend, or the possession of any sordid motive.

Mr. Shaw came forward and exposed Mr. Carter's utter disregard of truth. It seems, in the first place, that Mr. Shaw did send the patient to the "eminent consultant." What is more, the latter did not accept a fee for the consultation. A Baron's operation on the right upper eyelid was decided upon at the consultation, and was subsequently performed. All other operative procedures were condemned by both Mr. Shaw and the "consultant." The remedy given

the patient was arsenic. Mercury was never prescribed. When the patient left Mr. Shaw's treatment he was not suffering from salivation of any kind.

Dr. Dudgeon also came to the front, reminding the profession of Mr. Carter's Quixotic attempt to down homœopathy in the celebrated "*London Times* controversy," wherein he posed before the world as "R. B. C." The bad logic of that individual was fully exposed.

The fourth letter was from Mr. Spencer Watson, who hoped that Mr. Carter would fully ventilate the subject in the columns of the *Lancet*, and "get up a memorial to be signed by all regular practitioners of all societies, condemning the holding of consultations with homœopaths, and urging the Councils of all the medical societies to issue a protest to their members against such consultations." Yet he doubted the futility of his own suggestion.

The *Lancet* for August 9th was issued without containing a word concerning this great (?) controversy. How this must have hurt R. B. C.'s feelings, for in the issue of August 16th he says that he had refrained from noticing the letters of Mr. Shaw and Dr. Dudgeon, as he thought it possible "that some one else might desire to take part in the discussion." It really seemed as though no one else did want to take part, so Mr. C. had to enter the lists once more. He replied to Mr. Shaw's communication by saying that all his former statements were confirmed therein with the exception of two which were unimportant. To the disinterested Mr. Shaw's statement differs *in toto* from that of R. B. C. The only point of agreement was that a consultation did take place. To Dr. Dudgeon Mr. Carter replied in a "mebbe-I-was-and-mebbe-I-wasn't" style, and confines his remarks entirely to the question of his identity with R. B. C., of *London Times* fame. He announces that there are upright homœopaths whom he could respect.

"If such a homœopath brought a patient to me about the nature of whose case I was doubtful, I should not hesitate to examine the patient\* and to declare my opinion in the presence of the homœopath.† If I were asked to perform an operation, I should have no objection to the presence of a homœopath in the room; but I should stipulate for complete and undivided control of the treatment. . . . Just as . . . Mr. Balfour would not consult with Mr. Parnell‡

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\* Presumably for a fee.—Eds.

† As an invitation to bring another patient.—Eds.

‡ Mr. Parnell could probably give Mr. Balfour some pretty good advice which would stand that gentleman in good service.

concerning the means to be employed for the pacification of Ireland, so a medical practitioner has no moral right to engage in a consultation which can be no better than quackery ; a mockery, and which is calculated to deceive the patient and the public."

In closing, R. B. C. shows his surprise at Mr. Shaw's and Dr. Dudgeon's replies in the issue of August 16th, for he says:

"Let me add that, although homœopaths have thought fit to thrust themselves into the discussions in your columns, the question is not one for them, but for us."

Surely he must have thought that in the columns of the *Lancet* he could abuse homœopathy to his heart's content and the editor of that journal would protect him from reply.

The *Medical Press and Circular* is nothing if not orthodox, and with such a good chance to attack homœopathy it could not remain silent. So in its issue for September 3d it begins to tell how much it does not know about homœopathy. It quotes approvingly all of Mr. Carter's bad logic, and then proceeds to air its own ignorance thus:

"Either the professing homœopath is a true disciple of Hahnemann or he is not ; either he believes that the billionth of a grain of calomel is the correct dose and that three grains is a pestilent poison or he does not ; either he believes that morphia will on the *similia similibus* principle cure coma or he does not."

None of the above provisions enter into a homœopath's belief, though it is true that he does believe, in fact he knows, that morphia will cure *some* cases of coma. In this he is supported by the testimony of the *Medical Press and Circular* itself, for on the same page as the above-quoted assertion and almost alongside of it we read that the effects of the bites of a certain spider are narcotic and that morphia is the proper antidote. "O, consistency thou art a jewel!"

At present everything is quiet. The men whom Mr. Carter libelled have offered their explanations. He has gotten in a rejoinder, apparently in the hope of starting a "big fight." No one seems to agree with Mr. Carter, nor does any one seem to want to fight with him. It really seems that no one wants to take further part in the discussion. He is now being treated with that potent weapon, SILENCE.

## "SIGNS OF THE 'TIMES.'"

THE *Pittsburgh Medical Review* for September, 1890, has, as its leading editorial, a review of the *New York Medical Times* for August, 1890. It is headed "Signs of the 'Times,'" and opens as follows: "The *New York Medical Times* is the most prominent and influential homœopathic periodical in this country, if not in the world." . . . "It is edited by Egbert Guernsey, of New York, etc." The balance of the article is an adverse criticism on homœopathy, based on the contents of the August number of the *Times*. The burden of the criticism rests on the point, that out of 67 articles from current medical literature only two are credited to homœopathic sources. The writer then moralizes, that "if the most prominent homœopathic journal in this country gives less than four pages of homœopathy in thirty-two of reading matter," . . . "how much of homœopathy is there in it?" The editors of the *Pittsburgh Medical Review* are presumably honest men, yet it is evident that they have either deliberately misrepresented the truth, or that they are guilty of avoidable ignorance. The *New York Medical Times* is not "the most prominent and influential homœopathic periodical in this country, if not in the world." In fact, it is not a homœopathic journal at all. This statement is made on the written declaration of one of the editors of the *New York Medical Times*, which, by the way, is edited by Egbert Guernsey, M.D., and Alfred K. Hills, M.D., the latter, the working editor, being a member of the Medical Society of the County of New York (allopathic.) Dr. Alfred K. Hills, in a written communication to the secretary of the Allopathic Medical Society of the County of New York, in 1884, "I am not an editor or associate editor of any homœopathic medical journal." Yet at that time Dr. Hills was the principal editor of the *New York Medical Times*. Dr. Hills has since joined the American Medical Editors' Association, an organization composed, as the editor of the *Pittsburgh Review* knows full well, entirely of allopathists. It is plain that the editors of this journal did not, and do not, consider their periodical to be a homœopathic journal, and it is certainly more than gratuitous on the part of the editors of the *Pittsburgh Medical Review* to say that the *New York Medical Times* is "the most prominent and influential homœopathic periodical, etc." This journal, like all other allopathic journals, frequently contains homœopathic articles and clippings. But the *Times* differs from the other self-styled "regular" journals in possessing the moral courage and common honesty to accredit truthfully their source.

# GLEANINGS

## GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

ON THE EMPLOYMENT OF COLD BATH IN THE TREATMENT OF PNEUMONIA. By M. Barth (*L'Union Médicale*, July 3, 1890).—It has, for a long time, been considered that the effect of the cold bath was the direct abstraction of caloric. This certainly is one of the most important and the most readily apprehended, but it is not the only effect. Its action is first upon the circulatory system. During the immersion the vessels of the surface contract, the blood flows towards the viscera, its tension is augmented, and with it the work of the heart. After the bath an energetic reaction takes place, the blood flows back to the superficial vessels and leaves the visceral cavities. The nervous system is energetically stimulated; the brain becomes active; delirium ceases; the pulse increases in form; respiration becomes more regular; secretion is promoted; saliva and perspiration become abundant; but it is more especially upon the urine that the cold bath exerts any influence; even albumin, if it had existed, disappears. The action of the cold bath is not merely antithermic, but it is actively therapeutic.

THE REVIVAL OF VENESECTION.—Crocq is a great believer in the value of venesection in pneumonia, and places but little credence in that theory which assigns to this disease a microbial origin. He says that to-day physicians show too much confidence in the work of the laboratory and too little in clinical facts. Formerly the symptoms observed at the bedside furnished the indications for treatment; now the microbes are sought for in order to make a diagnosis. The old masters bled their patients suffering from pneumonia and cured their cases; physicians of the younger generation while searching for the microbe lose their cases. The same remarks are applicable to inflammatory rheumatism and puerperal peritonitis, in both of which affections a bleeding does good, while the patient fares badly when the extermination of the microbe is the object desired in the treatment. Nature often steps in and produces a hæmorrhage, which has salutary effects. Why should we not follow that hint? Some make the excuse that constitutions to-day are not what they were formerly; we live in an age of nervous degeneration. But we meet to-day the same congestions in different organs as we met years ago, and in these a timely bleeding will to-day give the same relief as it did of yore. Crocq does not believe in therapeutic systems that are constantly changing; all the therapeutic measures must be taken with intelligence and without exaggeration.—*Semaine Médicale*, 32, 1890.

A NOVEL METHOD OF APPLYING DRUGS IN SOLUTION.—Botey first introduced fluids into the trachea and allowed them to run down through the bronchi so that they could be absorbed through the lungs. After experimenting on animals he then tried the procedure on himself. He injected through a syringe five, then ten, and fifteen, and, finally, thirty-seven grammes of distilled water, allowing the fluid to run slowly down the walls of the trachea. It caused neither cough or irritation; the pulse beats fell from 84 to 74 and respirations from 21 to 17. Encouraged by these results he experimented with the method on a patient suffering from syphilis of the larynx and trachea, injecting twelve grammes of a fluid containing one per cent. of a salt of iodine. As the larynx had not been anesthetized it caused her to cough. Two days later an injection of fifteen grammes of the same solution was used, and some days afterwards twenty-five grammes; these latter she bore well without any trouble whatever. After seventeen such treatments she was pronounced cured; all other treatment had failed to benefit her.—*Allgem. Med. Centr. Zeitung*, 34, 1890.

**HERPES ZOSTER FOLLOWING INFLUENZA.**—At a meeting of the Medical Society of Bologna, Dr. G. Finzi reported a case in a girl of fifteen who, after recovering from a severe attack of influenza, was seized with neuralgic pain, accompanied with a pricking and burning sensation shooting from the back around the right side. On being seen five days later, a chain of herpetic vesicles was found extending along the seventh intercostal space, the lymphatic glands in the axilla being swollen and tender, and pressure along the course of the seventh intercostal nerve making the patient scream with pain. In from eight to ten days the vesicles disappeared, the whole duration of the symptoms having been about a fortnight.

At the same meeting Dr. Camillo Moglia reported a case of herpes zoster corresponding to the eighth intercostal nerve of the right side in a girl of eighteen, in whom the disease appeared at the beginning of an attack of influenza and lasted a month.

In Dr. Finzi's case antipyrin relieved the pain, but Dr. Moglia's patient proved refractory to treatment.—*Journ. of Cut. and Gen. Dis.*, September, 1890.

**ATROPHIC LINES AND SPOTS FOLLOWING TYPHOID FEVER.**—Dr. F. J. Shepherd, of Montreal, presented a case of this disease to the recent meeting of the American Dermatological Association. It had occurred in a boy of fifteen years, brought to the hospital with typhoid fever. During the course of the disease he was delirious and had epileptic attacks. Macular lines formed, extending across the patellas and around the anterior aspect of the thigh to near the middle, some being several inches long. They were of a reddish color, and afterwards became paler; they were not distinctly shiny and were grooved. The interesting point in the case was the occurrence of the atrophic lines in a boy during acute fever. He did not think that their presence could be accounted for, as they were in oedematous subjects, by stretching. There seemed to be a nerve element in their causation.—*New York Medical Journal*, September 20, 1890.

**SECOND INFECTION WITH SYPHILIS.**—Dr. Taylor reported the case of a sickly looking woman, aged thirty-eight, who entered the Charity Hospital in January last. Eleven years ago she had syphilis, having had a hard swelling of the external genital, enlargement of the glands, an eruption shortly afterwards all over the body and headache at night. In the second year she had rheumatoid pains and mucous patches, and in the third year serpiginous syphilides, etc. She married and gave birth to two sickly children, who soon died. Her husband having died, she again lapsed in virtue, and came to the hospital with typical miliary syphilides scattered over nearly the whole surface. All the ganglia were decidedly enlarged. There were mucous patches of the tongue and mouth, and evidences of alopecia. She suffered with pain in the joints, worse at night. The second attack was much more severe than the first.—*New York Medical Journal*, September 20, 1890.

**GLANDERS MARKED BY CATARRHAL PNEUMONIA.**—Dr. Hartge, writing in *St. Petersburger Medicinische Wochenschrift*, gives an account of the case of a veterinary surgeon who had been engaged in treating horses for glanders, and had subsequently worked in the laboratory of the Dorpat Veterinary Institute at bacteriological investigations of this disease. During last November, while he was working in the laboratory, he had an attack of influenza which kept him three days in bed, and which was followed by a severe and persistent cough, for which he was advised to keep in-doors. He did not follow this advice, and about three weeks after having returned to work was seized with a rigor and a feeling of discomfort in the chest, which was followed by stabbing pains in the side. On examination, he was found to be suffering from bronchitis and catarrhal pneumonia, which were supposed to be consequences of the influenza. There was then no albuminuria, and the temperature was not more than a degree above normal. On the sixth day, however, a considerable quantity of albumin was found in the urine, and the temperature was 40.6° C. On the seventh day the lungs still appeared to be affected with capillary bronchitis. There was little cough, but the sputum was tinged with blood. The patient now began to complain of severe pains in the joints of the feet, which were tender, but no swelling could be detected. The next day the knees became painful, and a slight swelling could be detected around the ankle-joint, which was excessively painful. Some small red eminences appeared in the neighborhood similar to those of erythema nodosum, and the knee-joint was swollen and distended with fluid. The next day (the ninth) the patient was generally worse, and there was dyspnoea, but it was not until the tenth day that the infectious nature of the disease

was suspected. The raised spots became livid, and there were streaks of lymphangitic character about the feet. The nose and face became red and swollen, and there was a sanguino-serous nasal discharge. The diagnosis was fully cleared up on the examination of this discharge at the Veterinary Institute by the detection in it of Löffler's glanders bacilli. The next day pustules broke out in various parts, and great numbers of Löffler's bacilli were found in the pus contained in them, with a remarkable absence of other micro-organisms. The patient died on the twelfth day. A post-mortem examination could not be obtained. Dr. Hartge remarks upon the difficulties of diagnosis which glanders frequently presents. At first the symptoms are so little distinctive that diagnosis is usually impossible; subsequently they may be mistaken for those of pyæmia, and in chronic cases for those of syphilis or tuberculosis.

In the present case the nature of the disease was masked by the catarrhal pneumonia which was present. The true proof, of course, is the detection of the glanders bacilli of Löffler and Schütz. In this case not only were these found, but guinea-pigs and mice, which were inoculated with the nasal discharge, became affected by the disease. In acute cases, according to Dr. Hartge, the prognosis is always bad; in chronic cases about 50 per cent. recover. The incubation stage is generally from three to five days, but may last longer.—*The Lancet*, July 26, 1890.

**BLEACHING TEETH.**—A dirty-looking, blue-tinged tooth in the front of the mouth is so distiguring to the appearance that the subject seeks the aid of the dental surgeon. Such teeth are too often recklessly and ruthlessly excised, and an artificial crown attached to the root. The result is brilliant, as far as appearance is concerned, and does not call for any great amount of labor on the part of the operator, but, at the same time, it is a question whether the true conservative treatment would not rather be to render the tooth presentable by bleaching and subsequent filling, which is practicable in a large number of cases. The most common cause of staining is the death of the pulp and infiltration of the dentinal tubules with the products of its decomposition. Another cause, which is much more common than it should be, is the insertion of amalgam stoppings, especially those containing copper, and this stain, unfortunately, appears to be indelible.

Two general classes of substances have been introduced for bleaching teeth—oxidizing agents, such as chlorine compounds and peroxide of hydrogen, and reducing agents, as sulphurous acids. The treatment by means of peroxide of hydrogen is extremely simple, and gives good results, but it appears from recent experiments by Dr. Miller, of Berlin, that this preparation acts upon the dentine, removing the organic matter.

Sulphurous acid is also open to a similar objection, in that its prolonged use will dissolve out the lime salts. Generally, the chief chemical used for bleaching teeth is chlorine or some of its compounds. Where chlorine is used, steel instruments are inadmissible, as the salts of iron, which would be formed, would rapidly discolor the teeth. The instruments must be constructed of gold, platinum, or ivory. In order to prevent the chlorine from passing through the foramen at the end of the root, which would probably cause acute periostitis, the apical third of the pulp canal is solidly filled with gold. The tooth is isolated at the gums, the soft parts being protected by the adjustment of the rubber dam, and the tooth thoroughly dried by means of a warm-air syringe. The pulp-cavity is then washed thoroughly with ether to remove any fatty material. Various preparations of chlorine have been recommended, but perhaps the simplest is freshly-made chlorine water, as suggested by Dr. Wright, of Richmond, U. S. A., which is forced into the pulp-chamber by means of a syringe. Three or four sittings, of an hour each, are usually sufficient to remove the discoloration, when the teeth can be filled in the ordinary way.—*The Lancet*, July 19, 1890.

**CHROMIC ACID FOR HYPERIDROSIS OF FEET.**—Experiments were made in 1889, by order of the Prussian Minister of War, with chromic acid to test its power of relieving excessive sweating of the feet, and the results have been highly satisfactory. Frequently, one application of a 5 per cent. solution of chromic acid sufficed. The solution should be applied with cotton-wool to the soles of the feet and between the toes; it is seldom necessary either to repeat the treatment or to apply a stronger solution. The parts treated by the solution become firm and dry, and the power of walking is much increased. If there are wounds on the feet, they had better be healed before applying the chromic acid. No secondary affection or inconvenience of any kind attends the treatment.—*Journal de Médecine de Paris*.



**AMYLOID DEGENERATION OF THE LUNG.**—Dr. Alexander S. Egoroff, of St. Petersburg, contributes a short monograph on this subject (*St. Petersburg Inaugural Dissertation*, 1890, No. 52, p. 36), based on his own researches in Professor N. P. Ivanovsky's laboratory, as well as on the study of (a rather scanty) international literature. His materials consisted of twenty-two bodies, presenting lardaceous disease of the kidneys, liver, and spleen; in four of them the lungs also proved to be similarly degenerated. Of the four cases, three referred to patients (two women, one man, æt. from 26 to 46) who had been suffering from pulmonary tuberculosis; the fourth to a syphilitic man of 47. The presence or absence of waxy degeneration was determined by means of (a) Virchow's iodine test; (b) methyl violet-test (which stains amyloid substances in a beautiful carmine red-color, recommended by Cornil, Heschl, and Tuergens); and (c) Leonardi's violet ink (recommended by Heschl and Birch-Hirschfeld). The following are the essential conclusions reached by Dr. Egoroff:

1. The respiratory tracts, including the lungs, are affected by lardaceous degeneration by far more frequently than is usually supposed. (According to Hennings, Kyber, Fehr, and others, the lungs are found to be degenerated in about 2 per cent. of all cases of amyloid disease; according to Dr. Egoroff, in about 18 per cent.)

2. The most common cause of waxy degeneration of the lung is constituted by pulmonary tuberculosis. (The same holds true in regard to amyloid disease of the abdominal viscera. Of the author's twenty-two cases, in ten (46 per cent.) pulmonary tuberculosis was present.)

3. As a rule, pulmonary lardaceous disease does not attain such intensity as observed in cases of amyloid kidney, liver, or spleen. The degeneration occurs in the shape of fairly small-sized isolated foci, irregularly scattered over the organ, and gradually decreasing in number in the direction from the bronchi towards the pulmonary alveoli.

4. The morbid process starts from the basal membrane of the bronchial epithelium, and from the membrana propria of the muciferous glands, to spread on the adjacent non-striated muscle fibres, bloodvessels, and connective tissue.

5. The degeneration never attacks the epithelium of either small bronchi, or muciferous glands, or pulmonary alveoli.

6. Of the bloodvessels, only the bronchial arteries, with their branches and capillaries are affected.

7. There does not exist any parallelism between the intensity and extent of lardaceous changes in the lungs and those in other organs of the body. (In fact, of the author's twenty-two cases, in those four where waxy degeneration of the lungs was present, amyloid changes in the abdominal organs were by far less pronounced than in the other eighteen cases in which no pulmonary degeneration was found.)

8. It is just possible that pulmonary amyloid disease may develop primarily, or, at least, simultaneously with similar changes in other organs of the body.—*The Provincial Medical Journal*, August, 1890.

**SYPHILITIC INFECTION IN A PERSON HEREDITARILY SYPHILITIC.**—In 1879, the woman came to Dr. Taylor first, aged 19, for the treatment of a destructive syphilitic sore on the face, arising from hereditary syphilis, a clear history of which was afterwards given him by her mother, who had acquired syphilis three months before the child's birth. The child had a rash, condylomata, and snuffles, and was weakly. Five years after his patient's first visit, in 1885, she returned, and had then macular roseola and scaling syphilides all over the body, condylomata of the genitals, mucous patches of the pharynx, etc. The infection began in the right labium, and was contracted from the husband. The glands were all enlarged and there was alopecia. She had since been cured.—*New York Medical Journal*, September 20, 1890.

**MEASLES SUPERVENING UPON AN ATTACK OF URTICARIA PIGMENTOSA.**—Morel Lavallée describes a case of measles in a boy whose whole body was covered with urticaria pigmentosa lesions. The attack of measles was unusually severe, but ran a typical course, and ended with a fine branny desquamation, the tongue desquamating, too. Intense itching was present all over the body; but, in spite of his constant scratching, no new lesions of urticaria appeared. During the time that the eruption of measles was out, the urticaria lesions persisted unaltered. While the acute exanthem was out thick on all other portions of the skin, none would develop upon the urticaria wheals.—*Archiv. für Dermatol. und Syphilis*, Heft 4 u. 5, 1890.

## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

**BENEFICIAL EFFECT OF AMYL NITRITE IN CARDIAC COLLAPSE AFTER DELIVERY.**—The patient was suffering severely from mitral disease, which had improved in hospital with tr. stroph., etc. Immediately the placenta was expelled, great dyspnœa, coughing and pretty free hæmoptysis arose, with lividity of face. She was given five or six drops of amyl nitrite to inhale. The effect was immediate, and red flushings supplanted the lividity, though very little blood escaped from the uterus. The good result is attributed by Dr. Wright who reports the case, to the nitrite of amyl allowing much blood to lie in the peripheral circulation, and so enable the weak heart to tide over the sudden strain given to it by the extra amount of blood thrown on the circulation after the placenta was expelled.—*Edinburgh Medical Journal*, December, 1889.

**THE UTERINE ANTHROPHORE.**—Dr. Falk has adapted the ordinary urethral anthrophore for the treatment of endometritis. After disinfection of the vagina the anthrophore is introduced into the uterine cavity with the aid of a speculum and dressing forceps. In ten minutes the medicated coating will have dissolved and the spiral can be removed. The endometrium can be treated in this way uniformly and with exact doses of the medicament, which is not possible by fluid washes or injections, as the amount of medication is unknown or unevenly distributed. The best results in fungous endometritis have been obtained with anthrophores containing chloride of zinc (1 per cent.), cuprum sulphuric. (0.3 to 1.0 per cent.), resorcin (10 per cent.), tannin (5 to 10 per cent.), and in gonorrhœal endometritis from corrosive sublimate (0.1 per cent.), kreosote (2 per cent.), and especially from sublimate (0.1 per cent.) combined with chloride of zinc (1 per cent.). As uterine colic often follows soon after the introduction of chloride of zinc, resorcin and kreosote, the anthrophore is given a coating of cocaine so that this method of treatment becomes painless in most cases.—*Centralblatt für Gynäkologie*, No. 33, 1890.

**THE INFLUENCE OF SYPHILITIC INFECTION DURING PREGNANCY.**—Schröder and prominent syphilologists state that a woman who is healthy at the time of conception and is afterwards infected during the pregnancy, will give birth to a healthy child, also that the exceptions to this rule are exceedingly rare. Winckle, P. Müller and Zweifel do not accept this statement, and are of the opinion that the fœtus becomes syphilitic more certainly in proportion to the early period of pregnancy in which the mother is infected.

P. Steffek, of Würzburg reports two cases in which the mothers were infected in the fifth month, and labor occurred in one case twenty-three days before full term, and in the other case forty days prematurely. In the latter case the child died before labor, and in the other, soon after. Both placenta were syphilitic. The time of infection was positively known in these cases.—*Centralblatt für Gynäkologie*, 33, p. 587, 1890.

**FROZEN SECTIONS OF THE FEMALE AT THE CLOSE OF PREGNANCY.**—Braune and Zweifel in sections made at this time, found that the uterine muscle was of even thickness throughout, without any sign of the ring of contraction.—*Centralblatt für Gynäkologie*, 33, 1890.

**THE PREPARATION OF CATGUT.**—The best method of the hardening and sterilization of catgut is a subject which has engaged the close attention of many physicians. Döderlein, of Leipsic, believes he found it in a modification of the method used by Lister in 1884. He writes: "After numerous extensive experiments, I have finally decided on diluting chromic acid, one part in ten thousand, and allowing the catgut to remain ten minutes in this solution. I then dry the gut carefully and sterilize it for two hours at 130° C."—*Centralblatt für Gynäkologie*, 30, 1890.

**THE RESULTS OF ASEPTIC LAPAROTOMIES.**—In the latter part of 1889, H. Fritsch invented an apparatus for the preparation of sterilized water. He writes: "As we gradually increase our knowledge of the inherent germicidal powers of healthy living tissue, we observe that one function of the human organization is to protect itself from bacteria and to destroy them. We must endeavor to strengthen the tissue rather than to depress their vitality by cauterizing or irritating solutions.

There are no antiseptics which do not injure the functions of some cells. Take ciliated epithelium for example; the addition of anything, even pure water, will injure its vitality. Only in a physiological solution of salt water is the physiological function retained. From a practical and technical standpoint I desire to emphasize that any injury to the physiological function of the peritonæum is a source of serious injury.

"As the result of long experience and study, I have come to the conclusion that the peritonæum must remain free from all chemicals, and can recommend the use of a sterilized solution of 0.6 per cent. salt and water."

He reports fifty-two consecutive laparotomies with two deaths, one from hyperemesis and the other from ileus. His method is the following: Thorough cleansing of the skin of the patient and hands of the operator. Steam sterilization of the clothes, sponges and instruments. Sterilized water alone is used for washing the hands of the operator, sponges, instruments and for cleansing the wound and abdomen. No thermal disinfectant touches the wound at any time.—H. Fritsch, *Centralblatt für Gynäkologie*, 29, 1890.

CONTRIBUTION TO THE DIAGNOSIS OF SALPINGO-OVARITIS.—Prof. Lebedeff, of St. Petersburg, has observed in several cases that the dimensions of the tumor vary very much at the menstrual periods. At the beginning of the period, the salpingo-ovarian tumor increases in size and, after that period, the tumor is much smaller or may have entirely disappeared. Oftentimes, one side is swollen and the other side in a collapsed condition at the time of menstruation, and at the next month these conditions are reversed. The change of size is most marked with small tumors and is due to the increased afflux of blood and collection of it in the tube (Schróeder); also to the ripening of a Graafian follicle. This sign allows the diagnosis of unilateral disease to be made if, after repeated examinations just before menstrual periods, the same side is always found to be swollen.—Dr. S. Michnow, *Centralblatt für Gynäkologie*, No. 32, p. 563, 1890.

ACTION OF PHOSPHORUS ON THE UTERUS.—In the examination of the uterus of a woman who died from phosphorus-poisoning, Overlach found cells in the altered mucous membrane which showed all the characteristics of decidua cells. Pregnancy could be excluded with certainty.—*Zeitschrift für Geburtshilfe und Gynäkologie*, Bd. xix., H. 2, 1890.

The above is quoted from an article by Overlach, entitled "Die Pseudomenstruierende Mucosa Uteri nach Acuter Phosphorvergiftung," *Archiv für Mikrosk. Anatomie*, p. 191, Bd. 25, 1885.—G. R. S.]

THE ORIGIN OF EPITHELIAL OVARIAN TUMORS.—Epithelial ovarian tumors, especially the cystomas, are known to be of epithelial origin, and the opinion that colloid tumors originate from the connective-tissue cells of the ovarian stroma, has been completely abandoned. Whether the epithelial ovarian tumors arise from the germinal epithelium or follicle epithelium, has been a debated question. P. Steffert has made a careful study of it, and has come to the conclusion that they grow from proliferation of the follicle epithelium. He has been able to procure microscopic sections of the process which appear to demonstrate his theory of follicular origin. He writes: "The changes which occur in a follicle undergoing proliferation, appear to me as follows: The cells in the membrana-granulosa grow vigorously and the follicle loses its normal contour. With this process, the epithelium along the wall of the follicle becomes markedly cylindrical and with this the change in the follicle is more pronounced, irregular, and finally prolongations or outgrowths of the follicle epithelium in the neighboring tissue are observed. The ovum gradually disappears. The larger the cyst, the more exuberant is the growth of the epithelium and in the epithelial-prolongation the cylinder epithelium is especially pronounced. It appears that the power of proliferation must be ascribed to the cylinder-epithelium, cells of which, like those of the membrana-granulosa, are found later only in the lumen of the newly-formed, gland-like cavity."

He is of the opinion that the epithelial tubes or balls, found in cysts, are neither primary or secondary formations from the germinal epithelium, but are the result of the closure of what might be termed the neck of one of the above-mentioned epithelial prolongations belonging to an adjoining cyst. The further destination of these epithelial balls or cylinders is, that cysts develop from them or, if they proliferate and remain solid, they assume a malignant character. "Zur Entstehung der Epithelial Eierstockgeschwülste."—Dr. P. Steffert, *Zeitschrift für Geburtshilfe und Gynäkologie*, Bd. xix., H. 2, 1890.

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**HEARING WITHOUT EARS.**—Dr. Richard Ewald, who is known as a most careful and skilful experimenter upon the brain, makes a most remarkable communication in the *Berliner Klinische Wochenschrift*, describing experiments which he had recently performed to ascertain the effect of total destruction of all the external and internal parts of the organ of hearing, except the internal auditory nerve and parts more central. By a most elaborate and painstaking operation, requiring for each side operated upon from four to six hours more of time, Ewald removed from pigeons all of the hard and soft parts connected with the external ear, the middle ear and the labyrinth, and left nothing but the stump of the internal auditory nerve. The most remarkable result of this operation was the discovery of the fact that within a few hours these animals gave distinct manifestations of being capable of hearing. Every precaution required by scientific accuracy seems to have been observed in these experiments, and the conclusion of Ewald—remarkable as it is—seems to have been established, namely, that pigeons can hear without any ears. After these operations, however, he found that he could produce degeneration by cauterizing the root of the internal auditory nerves with a little croton oil or with some arsenic paste, and that in these cases the pigeons became totally deaf. —*Medical and Surgical Reporter*, September 13, 1890.

**THE RECOGNITION OF EYE-STRAIN BY THE GENERAL PRACTITIONER.**—Edward Jackson, M.D., in a society paper, states that the attempt to give relief from the symptoms of eye-strain by a careful trial, seriatim, of one's favorite sedative, tonic and alterative prescriptions, followed by experimentation with the formulæ of great professors found floating on the surface of medical journals, does not usually bring much comfort to the patient or credit to the doctor. And that it is so frequently persisted in until the patient deserts his so-called medical adviser, and of his own notion takes his chances with the charlatan, seems to argue an inability to recognize the connection of this group of symptoms with their cause.

From time to time efforts have been made by ophthalmologists to secure a more general recognition of eye-strain on the part of the mass of the profession; but usually these efforts consisted in a recommendation of some special instrument or procedure of diagnosis, as the refraction ophthalmoscope or the shadow-test, or a set of trial lenses, reduced in size and price to the supposed needs of the mass of the profession. If it were really necessary to apply such means of diagnosis in order to recognize the presence of eye-strain, there would be little prospect of its early general recognition. But it is frequently recognized by the patient himself, and the ophthalmic surgeon finds in the general rational symptoms quite sufficient grounds for a provisional diagnosis; and if the mind is clear from preconceived hypotheses as to the cause of the symptoms tending to divert attention from their real origin, there is no reason why any one respectably qualified for general practice of medicine should not be able to make a provisional diagnosis with sufficient certainty to serve for the basis for further investigation and treatment, in the great majority of cases, without resort to any special method of examination whatever. Of course, the ophthalmoscopic evidence of ametropia, when it can be obtained, is very valuable as confirming such a diagnosis; and I do not underestimate the value of the ophthalmoscope to the general practitioner, for I cannot regard any one who is unable to use the ophthalmoscope as properly qualified for general practice. But I do say that inability to measure refraction with the ophthalmoscope is no reason for failing to recognize eye-strain.

The patient suffering from eye-strain comes with a certain history and certain complaints which, carefully considered by the light of a moderate knowledge of the subject, clearly indicate the cause of the trouble in the great majority of cases. The symptoms in question may be considered separately.—*The Times and Register*.

**IMPAIRMENT OF VISION, EITHER QUITE TEMPORARY, MORE PROLONGED OR QUITE PERMANENT.**—A very characteristic form of temporary impairment of vision is that due to sudden relaxation of the accommodation. This occurs when the ciliary muscle has long been overtaxed, and especially in the latter hours of the day, when it is nearly tired out. The patient notices that the print or other

near object on which the attention is fixed suddenly becomes entirely blurred, compelling the cessation of the eye-work. After a moment, however, the power of again focusing the object returns and work can be resumed. The patient is apt to close his eyes for an instant, and, perhaps, rub them, and on again opening them finds the sight restored. If the eye-work is continued the failure of accommodation recurs, to again rapidly pass away; and keeping on with the eye-work, these periods of inability to see become more and more frequent, until, finally, they greatly interfere with the continuance of the work or quite prevent it. This form of impairment affects only the vision for near work.

Another temporary impairment is that due to spasm of the accommodation; it affects distant vision only, and is noticed chiefly by those whose distant vision is otherwise pretty good. It comes on after prolonged straining of the eye, usually for near vision, and lasts until the eye has gotten well rested. It is a valuable danger-signal, and should secure cessation from the work causing it until it has given place to normal relaxation. Permanent impairment of vision is brought about when eye-strain causes myopia or decided permanent damage of the choroid and retina.—*The Times and Register*, Aug. 23, 1890.

**HEADACHE AND ACHING OF THE EYES.**—Eye-strain should be the first thought suggested by any complaint of headache, for in our day and civilization it is by far the most common cause of that symptom. It enters as a factor into the causation of nearly all headaches not due to pyrexia, toxæmia or diseases of the brain or its membranes. The simple existence of headache, therefore, should suggest eye-strain; but frequently a careful inquiry as to the manner and time of occurrence of the attack and the location of the severest pain will be almost conclusive as to the origin of the trouble.

Often it comes on whenever the eyes are used, and is absent when the eyes have had a proper season of rest. The occasions of most severe requirement in the direction of eye-work are the doing of anything requiring accurate near vision, taxing both the accommodation and the convergence; or travelling, shopping, attendance at public gatherings, which entail more use of the eyes than the patient is at the time conscious of, and often under unfavorable conditions.

In hyperopia in young people, the accommodation is in excessive use so long as the eyes are open and the attention fixed on any visible object; and hyperopia is the most common cause of constant headache. The writer was formerly subject to a constant headache whenever confined to the house, and regarded it as caused by breathing vitiated air, until it was quite cured by the correction of his hyperopic astigmatism. Many persons have the same idea as to the causation of the headaches they always experience when attending the theatre or other place of public amusement, and which are really due to eye-strain. Others ascribe these headaches, and those experienced in travelling and shopping, to exhaustion. This is nearer the truth, only they commonly have in mind a condition of general exhaustion, whereas it is largely one of local exhaustion of the special nervous apparatus concerned in the act of seeing.

Congestion, irritability, or inflammation of the eyes and their appendages, should always suggest the suspicion of eye-strain. A single attack or manifestation of this kind has no special significance, but repeated attacks of inflammation, or prolonged congestion, or irritability, are exceedingly suggestive of a continuing cause; and the most common of these is the one now under discussion. No case of chronic inflammation of the margins of the lids, or of recurring conjunctivitis, or repeated styes, has justice done to it until it has been carefully investigated for eye-strain. Persons at the period when they begin to feel the effects of the loss of accommodation in presbyopia or absolute hyperopia, suffer from repeated attacks of conjunctivitis, which they commonly ascribe to "taking cold in the eye," but which are cut short by use of the appropriate lenses, and which, if unchecked, would tend to establish a chronic catarrhal condition, which is a chief discomfort in the lives of many people.

I should like, also, to call attention to car-sickness in connection with eye-strain. I have had eight or nine cases of this kind, all of which were relieved by glasses. One case was that of a gentleman who every journey had car-sickness. While he had the mydriatic in his eyes he went to Washington, and suffered no inconvenience whatever. Subsequently, after he had glasses, he made a trip to St. Paul without any of the former trouble. Recently I have had two cases—one that of a girl who could not ride a short distance in the street cars without vomiting. I found a de-

cided degree of hyperopic astigmatism. With the mydriatic in her eyes she rode home without her usual trouble.

A strange thing with reference to eye-strain is, that it often exists to an exceptional degree without showing any symptoms in the eye. The patient will often say that the eyes are perfectly good and have never caused any irritation. The reflexes seem to have settled in some other place. This is an interesting pathological and physiological question.—*The Times and Register*, August 23, 1890.

**A CASE OF HYSTERICAL MUTISM CURED BY SUGGESTION DURING HYPNOTIC SLEEP.**—M. Charazac relates the case of a young girl of eighteen who became dumb after severe pain experienced during a sudden movement fifteen days after the swallowing of a needle. The mutism, as frequently happens, was produced in her case in virtue of the accident as the chief hysterical symptom. The patient was persuaded that the mutism was caused by the swallowed needle, lodged, according to her, on a level with the left hypochondrium, where she felt a severe pain. Suggestion during hypnotic sleep restored speech during two days, but the needle and the pain, according to the patient, were not removed. A second time, the patient being put to sleep, the writer gave a hypodermic injection of morphia at the painful spot; the pain disappeared not to return, and, from that time the patient has not suffered a relapse.

**THE INFLUENCE OF SEX IN THE LOCALIZATION OF AURAL DISEASES.**—Loeseneberg, of Munich, remarks that most specialists consider deafness of the left ear the most frequent, while he has found that the right ear is more frequently affected among women. When both ears are affected, which is rarely the case among women, he found the left ear to be more deaf than the right one. These relations were studied out by him in about 3000 cases, 1790 of which were males and 1210 females (the children were included according to sex). Bilateral deafness was found in 1074 males and in 737 females; among this number the right ear was more deaf in 424 males and 340 females; the left ear was the worst in 647 males and 397 females. Deafness was equal in 238 males and 162 women. When only one ear suffers right-ear deafness prevails in women and left-ear deafness in males.—*Bull. Med.*, 62, 1890.

**BLACK EYE.**—There is nothing to compare with the tincture or a strong infusion of capsicum annuum mixed with an equal bulk of mucilage of gum arabic, and with the addition of a few drops of glycerine. This should be painted all over the bruised surface with a camel's-hair pencil, and allowed to dry on, a second or third coating being applied as soon as the first is dry. If done as soon as the injury is inflicted the treatment will invariably prevent the blackening of the bruised tissue. The same remedy has no equal in rheumatic sore or stiff neck.—*New York Med. Times*

## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

**PEROXIDE OF HYDROGEN.**—R. T. Morris contributes a short article in support of this excellent anti-suppurative agent, the properties of which do not seem to be generally appreciated. He calls it "the necessary peroxide of hydrogen;" for, while bichloride of mercury, hydronaphthol, carbolic acid and other antiseptics will prevent suppuration, there is but one agent that will stop it abruptly and sterilize a suppurating wound, the strong (Marchand's fifteen-volume solution) hydrogen peroxide ( $H_2O_2$ ). In brain abscesses, if injected superficially, it will clean out the tortuous channels and throw the pus out in a foaming mixture, chemically cleaning the cavity as regards microbes. It kills even anthrax spores in a few minutes. In appendicitis the abscess can be so sterilized as to remove all fear of infecting the peritoneal cavity. Psoas abscess, suppurative mastitis, purulent conjunctivitis, and fetid ozena are likewise successfully treated. In the eye, nose and urethra some smarting is caused, which may call for the use of an anæsthetic; elsewhere it is as bland as water. Diphtheritic membranes will come away easily after its application. The solution should be kept tightly corked, when it will not decompose for

several months. Contact with metals causes its too rapid decomposition. Hydrogen peroxide should be used with caution about the hair, as it is used in the so-called golden hair bleachers.—*Times and Register*, September 20, 1890.

**URETERO-LITHOTOMY.**—Cabot reports an interesting case of a man, 40 years of age, who, for a period of three months, had suffered more or less constantly from attacks of colic which were referred to the left side, in the front of the abdomen, at a point just above the middle of Poupart's ligament. This pain did not extend down the thighs nor into the scrotum, although retraction of the testicle was noticed in some of the paroxysms. Some six years previous to these attacks he had suffered from what was supposed to be some appendical trouble. The last and most severe attack was on April 18th, when he was suddenly taken with a sharp pain which, unlike that of the previous attacks, continued persistently, but was paroxysmally aggravated. The abdomen was soft and flaccid, not tender, except slightly in the left hypogastrium, at the point where the pain was especially felt. Subsequently, a very sensitive spot was found in the back, midway between the iliac crest and the lower rib. This was constant, not disappearing during the intermission, and aggravated by pressure. Urine analysis showed a few hyaline and granular casts, together with considerable pus. Some five days after the beginning of the attack his temperature ran up to 101° and the pulse above 100. The next day the pain was so intense as to necessitate almost constant inhalations of ether. Vomiting also set in and the pulse was weak and frequent. Examination proved the above-mentioned point to be midway between the crest of the ileum and the lower rib, and gave also a sense of increased resistance which was thought to be due to muscular rigidity. A diagnosis of impacted calculus was made, and, after the patient was fully narcotized, an operation for the removal of the same was undertaken in the following manner: An incision was made along the outer edge of the quadratus lumborum muscle, from the lower border of the twelfth rib to the crest of the ilium. The space between the rib and the pelvis was very narrow, even after the trunk was bent strongly over pillows. The kidney was found to lie very high under the ribs, so that only its extreme lower end could be seen. Examination of this proved negative, after which the ureter was traced, and in it was felt a small hard mass about two inches below the lower angle of the wound. The ureter was drawn forward into view by means of a blunt hook, opened and explored with a fine needle, which showed the hard body to be a small calculus. It was readily removed by a small longitudinal incision. After exploring the ureter with a fine probe, a drainage-tube was placed in contact with the opening, and another was carried up behind the loose tissue around the kidney. The angles of the wound were sutured. The pains disappeared and gave way to soreness. The after-course was uncomplicated. The urine for a few days contained some little blood, after which recovery was uneventful.—*Boston Medical and Surgical Journal*, September 11, 1890.

**INJURY FROM THE USE OF ESMARCH'S BANDAGE.**—Stimsen presented a case to the New York Surgical Society on which he had used the above bandage while performing excision of the wrist. The tourniquet was applied about the middle of the arm. The wound healed kindly, but the patient, now some two months after the operation, is unable to move any of the muscles of the forearm or hand. The galvanic current showed some reaction. Starr, who had examined the case, thought the condition was probably due to either contusion of the nerves of the arm or else to the temporary ischæmia of the muscles caused by the band. Innervation through the three nerve trunks was completely lost, the reaction of degeneration was very marked, and seemed especially so in the interossei muscles. Starr believed the prognosis to be good.—*New York Medical Journal*, September 20, 1890.

**APPENDICITIS.**—Hartley in an interesting article on the above subject, emphasizes the importance of a proper appreciation of the condition, in order that the proper treatment may be instituted. Of 15 cases that were under the author's observation, 12 were males and 3 females. The youngest patient was 10 years of age, the oldest 30 years of age. The duration of the disease from the first attack was in 1 case, 2 days; in 2 cases, 9 days; in 1 case, 3 days; in 1 case, 12 days; in 2 cases, 4 days; in 1 case, 14 days; in 2 cases, 6 days; in 1 case, 17 days; in 1 case, 8 days; in 2 cases, 5 months; in 1 case, 6 years. Twelve cases were operated upon in their first attack, one case was operated upon on the third day of the second attack, one case was operated on the second day of the third attack. Another was operated on the nineteenth day of the third attack.

The location of the appendix in reference to the cœcum, was behind the caput coli in eight cases. In the others it varied, being found below the caput coli, attached to the abdominal wall, in front of the cœcum, over the brim of the pelvis, and on the anterior surface of the cœcum. The relation of the appendix is of importance, both in the diagnosis and in the method of operation. The point representing the junction of the cœcum and the vermiform appendix lies opposite a point marked by the middle and lower thirds of a line passing from the umbilicus to the middle of Poupart's ligament. Of the 15 cases, 4 were of the catarrhal variety, 4 of the suppurative, and 5 of the gangrenous variety. In two cases no distinct appendix could be recognized.

Of the catarrhal variety operated on in none were there adhesions present. In two cases there was stenosis more or less marked at the cœcal end. In two cases the temperature was normal at the time of operation. In one case with purulent foci the temperature was 102° F. In two of these cases the pain, which was at first general, was localized on the second day to the right iliac fossa. One case of chronic catarrhal appendicitis operated on the second day of the third attack, showed a chronic catarrhal condition with greatly hypertrophied walls, stenosis at the cœcal end and chronic plastic peritonitis. The temperature during this attack was 102°.

Of the suppurative variety stenosis was found in one case. In all the peritonitis was fibrinous, purulent, or purulent and circumscribed. The temperature ranged from 100.4° to 103.4°. They were all characterized by general abdominal pain, which was localized in the right iliac fossa. In none was there marked tympanitis, or prostration.

In the gangrenous variety, there were two cases in which no distinct appendix could be found; in two cases, stenosis was present, in one a calculus, and in two others, perforation existed. The peritonitis in all of these cases was of a fibrino-purulent variety, or a foul-smelling fibrinous exudation was present upon the intestines. The temperature was much the same as in the suppurative variety. Tympanites was present in three cases, and wanting or slightly marked in two cases. Of the four cases in which prostration was noticed, three died.

There appear to be no particular symptoms on which one can state definitely either the condition of the appendix or the probable course of the disease, except the presence or absence of its complicating peritonitis. The temperature elevation is of no value in these cases in a diagnostic sense. The severer cases often run their course with very little rise of temperature. The author believes the remittent or intermittent character of the temperature to be of more value. The thready, rapid pulse, cold perspiration, the cool extremities, with moderate cyanosis, with or without a contracted abdomen, and distension of the abdominal cavity are symptoms of value, especially if the pains start from the right iliac fossa. These symptoms are strongly suggestive of those cases, where there is a sudden perforation of the appendix, either directly where there are no adhesions present, or from the small abscess cavity in which the appendix lies, when the whole peritoneal cavity is at once involved. In the treatment of this trouble we should decide upon one or another method, depending upon what the pathological condition is. The cases are divided: 1. Into those in which in the first attack a complicating peritonitis exists at the time we see it. 2. Catarrhal appendicitis. 3. Those in which recurrent attacks of catarrhal appendicitis have occurred, and in which adhesions have bound the appendix to the cœcum, intestines or peritonæum over the iliac fossa or not.

In the acute and per-acute affections, peritonitis, depending upon a rupture of the appendix or abscess cavity about it and in those in which we find the symptoms of a marked intoxication, whatever is to be done must be done at once. In the class of cases where the whole peritonæum seems affected, the author believes in early operation and drainage as the only resource. In recurrent cases of catarrhal appendicitis the writer is of the opinion that the removal of the appendix is the only method to do away with the danger of subsequent attacks. In acute cases of catarrhal appendicitis seen in their first attacks, the author advocates the expectant plan of treatment, as by far the greater number recover from their first attack with at least an apparent resolution; about twenty-two per cent. (Kraft). Eleven per cent. (Letz) of these cases have recurrence sooner or later, which may take any course ending in peritonitis—septic, progressive, and circumscribed—in phlebitis, perforation into other organs, or in pyæmia. The writer concludes by reviewing, in an exhaustive manner, the various methods of operation and the after-treatment—*Medical Record*, August 16, 1890.



# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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CONDUCTED BY

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**APIS MELLIFICA IN CONGESTION OF THE BRAIN FROM EXPOSURE TO THE SUN.**—In the case of a boy, aged six, who had cerebral congestion following exposure to the sun, Dr. Oscar Hansen prescribed apis, 2 per cent. dilution, successfully, after belladonna had failed. Symptoms: He lay "in bed dull, sending out piercing shrieks; squints, bores with the head in the cushions; pupils dilated, contracting only a little against the light; pulse 72 per minute; no sleep; no urination."—*Homœopathic World*, August.

**CROCUS SATIVUS IN PLYCTENULAR KERATITIS.**—"Very painful sensation as if the eyes were turning round and round in their sockets. *Crocus* 2x every hour until better, then four times daily, secured marked relief from photophobia, lachrymation and the annoying symptom complained of. This prescription was effectual in turning the case toward recovery after one month of careful prescribing."—Dr. C. E. Walton, *Pulse Quarterly*, September.

**CACTUS GRANDIFLORA IN CARDIAC NEURALGIA.**—"Mrs. D. had been troubled for some weeks with occasional attacks of intense pain in the heart, accompanied by a feeling of oppression and fear of impending dissolution. The pain was described upon closer questioning, as of a *squeezing* character. *Cactus* 2x dilution, on disks, was prescribed, to be taken at the time of attack. Relief in every instance was almost instantaneous, and attacks became gradually less frequent, finally disappearing entirely."—Dr. Harvey Dale, *N. A. Journal of Homœopathy*, August.

**EQUISETUM HYEMALE IN ENURESIS.**—"Robbie B., aged six, had been troubled with nocturnal enuresis since birth. All sorts of remedies had been tried without avail. *Equisetum* 2x, night and morning, produced immediate improvement. Remedy was then persisted in for two months and then stopped. There has been no return of the trouble in over a year."—Dr. Harvey Dale, *N. A. Journal of Homœopathy*, August.

**HAMAMELIS IN MENORRHAGIA.**—"Mrs. M. had flowed terribly at every menstrual period for years. At time of visit she had been flowing profusely for over twenty-four hours, and was exsanguine and exhausted. *Hamamelis* 1x dilution, ten drops in half a glass of water, a teaspoonful every hour, relieved immediately. Succeeding menstruations have been normal, with one or two exceptions, when hamamelis helped at once."—Dr. Harvey Dale, *N. A. Journal of Homœopathy*, August.

**POLYPORUS OFFICINALIS IN PORTAL CONGESTION.**—Aching pains in region of liver. Mucous stools, or at times mucous blood and bile, with faintness and distress in epigastrium after stool. Tendency to yawn and stretch, indisposed to any exertion.—*Pulse Quarterly*, September.

**CHELIDONIUM IN HEPATIC CONGESTION.**—J. H. had suffered for many years with attacks of congestion of the liver, accompanied by the usual symptoms, in-

cluding intense and steady pain running back under the right shoulder blade. Bryonia, nux vomica, podophyllum and other remedies given by a homœopathist failed to relieve. *Chelidonium* 2x removed the pain at once, and soreness very quickly. Patient has ever since kept a vial of the chelidonium in his pocket, and at the first sign of the approach of the old trouble begins taking it, with uniform success up to date.—Dr. Harvey Dale, *N. A. Journal of Homœopathy*, August.

**TREATMENT OF BILIARY CALCULI AND ITS SEQUELÆ.**—Dr. P. Jousset, in *L'Art Medical*, August, 1890, treats this question, of which we give the following abstract: 1. Biliary lithiasis.—Different authorities recommend calcaria carb., hepar, lachesis, silica, sulphur, and especially china. In the treatment diet should be taken into consideration, as bad digestion is the most habitual and the most powerful cause of biliary lithiasis. Nux vomica and graphites will correct the gastric troubles.

Dr. Claude has published in the *Bulletin de la Société Homœopathique* a paper stating that the continuous administration of china constitutes a thoroughly efficacious remedy for biliary lithiasis. China in healthy man produces in small doses violent pressing and shooting pains in both hypochondriac regions < when walking and from the slightest touch and from forced respiration. Pains at the epigastric region excessively violent and radiating towards the heart; nausea and vomiting; jaundice and dyspepsia. Dr. Jousset has been less successful in the use of china, failing in some cases.

2. Hepatic colic.—After advocating the use of choral, antipyrine, and especially of hypodermic injections of morphine, as palliative measures during the attacks, because such analgesics relieve the pains in a few minutes and check the spasm of hepatic ducts, thus facilitating the passage of the calculi towards the intestines; he gives the following remedies with their respective indications:

*Belladonna*: Excessive pain forcing patient to bend double; pain associated with considerable distension and vomiting. *Dose*: 3x dil. to 3 gtt. in 200 grammes of water; spoonful every half hour.

*Chamomilla*: Similar to belladonna; considerable anguish; restlessness forcing the patient to continually change position. *Dose*: Same as under preceding remedy.

*Digitalis*: Indicated when violent pains are associated with a feeling as if life would be extinguished immediately. *Dose*: Same as the preceding remedies.

*Arsenicum*: Hepatic colic with syncope; patient unconscious; face deathly pale and covered with cold sweats; ineffectual efforts at vomiting. Hartmann with a single dose of arsenicum has cured these symptoms. Dr. Jousset states that a biliary retention in a child, of six years' standing, has been cured by continuous administration of *calomel* in minute doses.

3. ICTERUS.—*Nux vom.*: Associated with constipation, anorexia and indigestion.

*Cham.*: Same symptoms, only instead of constipation there is diarrhœa. *Dose*: 6x dil. four times a day.

*China*: Icterus with diarrhœa; hepatic pain < from pressure; marked aversion for meals; bitter taste and pyrosis. *Dose*: 6x dil. four times a day.

*Lachesis*; *vipera*; *crotalus*: Icterus with constipation; sweet or acid taste; great sensitiveness at the epigastrium; burning and cutting pains in hepatic region. *Dose*: 3x trit. or 6x dil.

*Digitalis*: Abundant vomiting, with choleraic diarrhœa. *Dose*: In benign cases, 3x or 6x dil., but during choleraic symptoms 2 gtt. of in 200 grammes of water; a teaspoonful every two hours.

*Chelidonium majus* produces, in healthy man and in animals, the icterus and other hepatic symptoms though not well determined. This drug entered in the traditional treatment of hepatic diseases since the doctrine of the signatures.

4. Malignant icterus:

*Aconitum*: Jaundice, multiple hæmorrhages, prostration; restlessness; anguish; delirium; intense febrile movements. *Dose*:  $\phi$ , 1-2 drops in 24 hours.

*Phosphorus*: The pathogenesis of phos. is so similar to malignant icterus that this disease has been taken for phosphorus poisoning. Icterus; vomiting; fever; delirium; followed by coma and death. Hypertrophy of the liver followed by rapid atrophy with fatty degeneration of hepatic cells. *Dose*: 3x to 6x dil.

*Lachesis*: Its action is perfectly homœopathic to this stage of the disease.

*Arsenicum* and *mercurius* are also indicated.

**REMEDIES IN MORVAN'S DISEASE.**—Dr. Samuel Lillenthal, in the *North American Journal of Homœopathy*, for August, in an article on "Morvan's Disease," suggests the following remedies:

*Thuja occidentalis*.—Erysipelatous swelling of the tips of the fingers and of the fingers; nails are crippled, discolored, crumbling; twitching of muscles of the arms; coldness and sensation of deadness of the fingers and of the tips of the fingers; stinging pains in the arms and in the joints; emaciation and deadness of the affected parts; dirty and brownish color of the skin.

*Silica*.—Scoliosis, complementary to thuja. Chronicity; emaciation and atrophy of the affected parts; paretic states; nails rough and yellow; pain as if paniritium would form on left index; dryness of tips of fingers; ulcers about nails; felons, with violent shooting pains deep in the fingers, with great restlessness and irritability.

*Sodium sulphate*.—Correlated to thuja. Later stage, when paronychia sets in, painless or with hardly any pain; twitchings of the hands; trembling of the hands on awaking and also when writing; loss of strength of the hand, is unable to hold anything heavy; tingling, ulcerative pain under the nail; internal coldness, with yawning and stretching.

*Mesereum*.—Emaciation of single parts (selenium); rachitis, inflammation, softening and caries of bones; ulcers of bones with morbid interstitial growth of soft parts; tearing jerks in arms and fingers; painful, darting and grumbling in the phalangeal bones, in paroxysms; sore pain under the nail of the right thumb, especially felt when pressing upon the part; great sensitiveness to cold air, chilly even in a warm room; ulcers about the joints of the fingers, very often painless (borax, sepia).

*Selenium* "has emaciation of face, thighs, hands, and may be therefore of service in that sclerodermitis deformans with its characteristic mark of the face, so graphically compared by Gilbert to the stony mark of Niobe."

*Graphites*.—Emaciation of the hands, distortion of the fingers, gouty nodosities on the finger-joints; thick and crippled nails; soreness between the fingers; sensation of debility without pain, and liability to take cold. Cracks and fissures.

*Sepia*.—Diseased and crippled nails, with painless ulcers on the joints and tips of the fingers and paralytic drawing and tearing in the arms and fingers. Venosity and stagnation; neurasthenia and paresis.

**TREATMENT OF ABSCESS OF THE LIVER.**—1. *Lachesis*.—Abscess of the liver is one of the lesions produced by snake-bites. The indications are jaundice, pain in the hepatic region, fever of remittent character and prostration. Dose, from the 3d to 12th dil., 2 gtt. in 200 grammes of water; a spoonful every two hours in acute cases and only four spoonfuls per diem in chronic cases.

*Vipera torra* is preferred to lachesis by some. It can be given in the 1st or 2d trit., 25 centigrammes in 200 grammes of water, in the same way.

2. *Mercurius*.—Indicated by the burning, lancinating or contusive pains in the hepatic region, by the hypertrophy and the hardness of the liver, by the jaundice and the fever with abundant sweats. Dose, same as the above.

3. *Arsenicum*.—Valuable in an advanced stage. The indications are prostration of strength, fever of a remitting character, and the grave state which accompanies internal suppurations. Dose, from 6th dil. to 3d trit., or, still better, the 2d trit.

4. *Silicea*.—Indicated in all suppurative processes, particularly when there is enlargement and hardness of the liver, pulsating pain, aggravated by touch and motion. Dose: The 30th dil. seems to have a more efficacious action than the lower dilutions. However, the success obtained by Jenichen's dilutions proves that the lower dilutions are also very efficacious; "lower dilutions," because those pretended to be 200 and 4000 of Jenichen are probably not more than the 4th dil. shaken 200 or 4000 times.

*Surgical Treatment*.—As soon as the presence of pus has been ascertained, surgical intervention becomes absolutely necessary.—Dr. Jousset in *L'Art Medical*, September, 1890.

**TREATMENT OF CIRRHOSIS OF THE LIVER.**—1. *Phosphorus*.—Wagner has demonstrated that chronic phosphorus poisoning produces an interstitial hepatitis with hypertrophy first, followed by an atrophy of the liver and a granular aspect. Phosphorus also produces jaundice, dropsy, and gastric troubles. This drug is clearly indicated in two varieties of cirrhosis, i.e., atrophic and hypertrophic. It has been

used with success by Dr. Salzer, of Calcutta. Dose: 3d and 6th dil., three times daily for twenty days; rest four days and begin again.

2. *Plumbum*.—Coutenot has observed hypertrophy and cirrhosis of the liver with jaundice: others, a painful and retracted liver. There is no known clinical fact that would justify the use of plumbum in the treatment of cirrhosis.

3. *Lycopodium*.—Dr. Childs reports a case of hepatic trouble with ascites having necessitated puncture sixteen times in one year (probably an atrophic cirrhosis), which, under lycop. 30th, was finally cured. The indications for lycopodium are: Painful liver on pressure, shooting pains; enlarged liver, ascites, with cedema of the lower extremities.

4. *Ferrum*.—Though the hepatic symptoms produced by this drug are not well defined, Cruvellier reports a case of hypertrophy of the liver with jaundice cured by this drug.

5. *Mercurius* has produced in the healthy man: Pains and weight in the hepatic region, enlargement of the liver and icterus. Dr. Piedvache uses this drug in the treatment of hypertrophic cirrhosis.

6. *Aurum*.—Homœopathic literature contains a certain number of cures of hepatic troubles with ascites by this drug. Though we have not yet many therapeutical means for the treatment of cirrhosis of the liver, nevertheless we must remember that this disease is not absolutely incurable as it is often thought. A milk diet is a powerful auxiliary in the treatment.—Dr. Jousset in *L'Art Medical*, Sept., 1890.

**PICRIC ACID IN ACNE.**—Miss F. had had a severe form of acne for many years. I treated her for several months with various remedies, and with considerable improvement. Her face, at the end of that time, was nearly smooth, with the exception of her chin and along the edges of the sides of the nose on either side. In these places there remained an eruption of indurated and elevated papules, rather dark red, painless, but sore to touch, and upon the surface of which there developed very small pustules. *Picric acid* 30x completed the cure.—Dr. E. H. Linnell, *North American Journal of Homœopathy*, July.

**MEZEREUM IN SCROFULOUS ULCER.**—"Mr. P., an unusually strong and vigorous man, had, when a child, a running sore on his face just in front of his left ear, which lasted for a long time, several years if I remember correctly, in spite of the efforts of several physicians, and was finally healed by some old woman's poultice. About a year ago, he consulted me saying that the old sore had broken open again, and remembering his childhood's experience he was anxious to have it promptly cured. On examination I found a small but rather deep ulcer in front of the tragus. It was somewhat indurated about the edges, and covered with a thick scab, seemingly formed of several layers resting one above the other. On pressing gently upon the scab, thick white pus oozed from under the edge. *Mezereum* 30 cured him.—Dr. E. H. Linnell, *North American Journal of Homœopathy*, July.

**ARSENICUM IN FURUNCLES.**—Dr. Oscar Hansen, with *arsenicum* 6c, cured a man who had been troubled for two years with recurring crops of boils. The furuncles appeared in various portions of the body, varying in size from a walnut to a hazelnut, were hard, red, movable over the underlying parts, and some of them discharged a little thick, yellow pus.—*Homœopathic World*, July.

**THE HYDROA OF RHUS TOXICODENDRON AND NATRUM MURIATICUM DIFFERENTIATED.**—"In intermittent fevers, as in other diseases, there sometimes occurs an eruption of hydroa, or fever blisters. Two very prominent remedies have this symptom, viz.: *Rhus toxicodendron* and *natrum muriaticum*. There is a slight difference in the appearance of these hydroa, which I consider diagnostic. The *rhus* blister is at first clearer, with a tendency to yellow or amber color, while the *natrum* blister is whiter or more of a pearly color. The *natrum* hydroa are more likely to be single and those of *rhus* in clusters."—Dr. G. M. Pease, *Medical Advance*, July.

**KALI BICHROMICUM IN OBESITY.**—Dr. Drysdale, in the August *Homœopathic Review*, reports that an extremely corpulent patient of his, suffering from dyspepsia and eczema, decreased in flesh rapidly while taking drop doses of *kali bichromicum* 1, night and morning. Upon stopping the medicine, the loss of weight stopped. A resumption of the medicine again brought about a reduction in flesh. The patient recommended the remedy to an obese friend, but in the latter individual the *kali bichromicum* was inoperative in securing a desirable flesh-reduction. Dr. Drysdale

believes that the obesity was reduced in the first instance because the medicine was prescribed for the totality of the symptoms, and failed in the latter because only a single condition was taken into consideration.

**ANTIMONIUM CRUDUM IN ECZEMA**—CASE 1.—L., a boy of 16, was treated by Dr. Kunkel, in 1885, for an eruption on the arms and face, for which he received sulphur and graphite without any benefit. In May, 1886, he was again brought for treatment. The eruption consisted of small pointed pustules, mainly on the forehead, which were painful to touch; washing the face with cold water and wet weather aggravated this sensitiveness. Painful rhagades of the angles of the mouth. Sleepy during the day; heavy sleep mornings, is very hard to awaken. *Antim. crud.* 10, every seventh day, a powder. In November, he was reported to have been well a long time.

CASE 2.—Frida D. has suffered from a small pustular eczema of the face and various portions of the body, bends of the elbows, etc. Itching, particularly in the morning, and when the air is warm. Sleepy about noon. *Antim. crud.* 10, six doses, one every seventh day. A year later, she was again brought for treatment, the eruption having remained away until a few days ago. Now it exists on the upper lip, eyelids, right wrist and bend of the elbows. Sleepy during the day, but worse evenings; occasionally about noon. Tendency to constipation and to cold feet. Horripilation, with desire for fresh air. *Antim. crud.* 10, a dose every seventh day. At first the eruption became worse, and then gradually improved.

CASE 3.—H., female, aged 22, presented herself for treatment in March, 1888. Menses always scanty. Tendency to congestions of the brain. Since November, 1887, has had a dry eruption on the cheeks, consisting of yellow, irregular plaques of various sizes, surrounded by dry, harsh skin. Flashes of heat, coming several times per day, and followed by burning pain in the eruption. Aggravation in a warm room and from excitement. Similar patches of eruption on the dorsa of the hands. Frequent attacks of dyspnoea and vertigo, particularly when the air is warm and moist. Stool often tardy. Marked relief from moderate exercise; sitting steadily disagrees. Dry skin. Headache always accompanies the heat which rises to the head. Is weak. Under sepia and *natr. mur.* some improvement occurred. In May she again noticed an aggravation from moist, warm air, headache and dyspnoea being produced. Sleepy during the day. Symptoms are relieved by lying down. *Antim. crud.* 10, a dose every seventh day. A cure was rapidly produced.—Dr. Kunkel, *Allg. Homœop. Zeitung*, July 24, 1890.

**PHOSPHORUS IN PSORIASIS**.—Dr. S. H. Haddock reports the cure of a severe case of psoriasis with *phosphorus* 200. A return of the disorder, six months later, quickly yielded to the same medicine.—*Medical Advance*, August.

**PETROLEUM AND EPITHELIOMA**.—The *Journal des Sciences Médicales de Lille* (July 11th) contains a memoir of Messrs. Derville and Guérmonprez, professors at the Faculté libre of Lille, upon the papilloma of petroleum refiners. Below we give the symptoms produced by petroleum: Warty lesions principally upon the fore-arm and the dorsum of the hands and fingers, (regions most exposed to the contact of petroleum). Papillomes upon one eyelid, upon the nose, scrotum and legs; probably developed by the contact of dirty hands. All these lesions follow a uniform course; it seems they begin by a small *red papule*, slightly elevated, smooth and very pruriginous from the beginning. Later this papilloma becomes larger and more elevated and soon at its centre is found a *small horny elevation*, hard, and as large as the head of a pin.

If this is not now cauterized by an energetic caustic, the central horny spot will gradually extend with the enlargement of the warty growth. When the size of a pea, the surface of the wart presents two distinct parts, one *central*, black, irregular, furrowed by superficial cracks of distinctly warty appearance, and the other *peripheral*, forming round the first a sort of raised areola, a bright red, striped, smooth, of an inflammatory aspect and whence the disease spread; all these lesions are *excessively pruriginous*, greatly interfering with the sleep of the patients.

In another patient there has also been observed a horny production, exaggerated at the level of the sortie of hairs. Those punctiform elevations, blackish, hard, were found upon the dorsum of the hand mostly of the first phalanx of the fingers, simulating exactly the characteristic horny cones of *psoriasis rubra filaria*. None of these growths were upon any portion of the body. The skin of forearms becomes dry and somewhat rough to touch: it is *gray*, black, hyperpigmented.

One of the patients (set. 61) had a papilloma on the scrotum with intolerable itching. Excision was made and the wound cauterized by carbolic acid, which was followed by an ulcerative wound of a triangular shape, with considerable and very fetid discharge.

Upon the core of the ulcer were two reddish nodules, bleeding at the slightest contact, one responding to the right testis, of an ovoid shape, and as large as a pigeon's egg, completely denuded. The other nodule responding to the left testis, is partly covered by scrotal skin and limited by warty and hard edges. Condition of patient: Diarrhœa, fever, delirium, great emaciation, face straw color, very weak; no family history for cancer; has seven brothers and sisters older than himself, all enjoying good health.

The patient died. A microscopic examination made by Professor Augier demonstrated that it was a true epithelioma.

The authors of this paper concluded that petroleum produces a papilloma and at least favors epithelioma if it cannot produce it. They suggest, in consequence, to try petroleum internally and externally in the treatment of epithelioma. Dr. Marc Jousset, reporting *L'Art Medical*, August, 1890, quotes from Allen's *Handbook of Materia Medica and Homœopathic Therapeutics*, art. Petroleum: "Nodules (in paraffine workers) on hands, wrists, arms, feet and legs; worse about wrists or wherever the dress is tight (palms and soles being free), less on face, neck and parts to which oily matters find access." We find also, "pimples itching on angle between scrotum and thigh, scabs in fold of left wing of nose."

**RHODODENDRON IN GONORRHOËAL SEQUELÆ.**—In the case of a young man who, previous to marriage, had contracted gonorrhœa, and who complained that he had drawing pains from the testicles into the abdomen and thighs, and contusive pain in the testicles, which were painful to touch, somewhat swollen, and one rather indurated, the trouble always being worse in wet and stormy weather, Dr. E. G. Grahn gave the patient *rhododendron* 3x. Early relief and a cessation of the trouble was the result.—*American Homœopathist*, September.

**LACHESIS IN RECTAL HÆMORRHAGE.**—Dr. Louise Lannin, in the *North American Journal of Homœopathy*, September, recites two interesting cases of bleeding from the rectum (for which no adequate cause could be ascertained) with *lachesis* 30, after many other hæmorrhagic remedies had signally failed. In one case there were present a few vague lachesis symptoms, and in case No. 2 the medicine was given because it cured the first one.

**CLINICAL VERIFICATIONS.**—In a paper read before the Clinical Society of the Hahnemann Hospital, of Chicago, Dr. Howard N. Lyon presented the following clinical verifications:

(a) *Headache from Loss of Breakfast.*—In three cases in which the patient was too busy to stop for breakfast, *calcareæ carb.* relieved the headache.

(b) *Headache Induced by Riding on the Cars or Over a Rough Pavement.*—*Arnica* has invariably afforded relief.

(c) *Sore Mouth from Travelling Over the Alkaline Deserts.*—*Borax*, either as a mouth-wash or internally, has been effective in a number of instances.

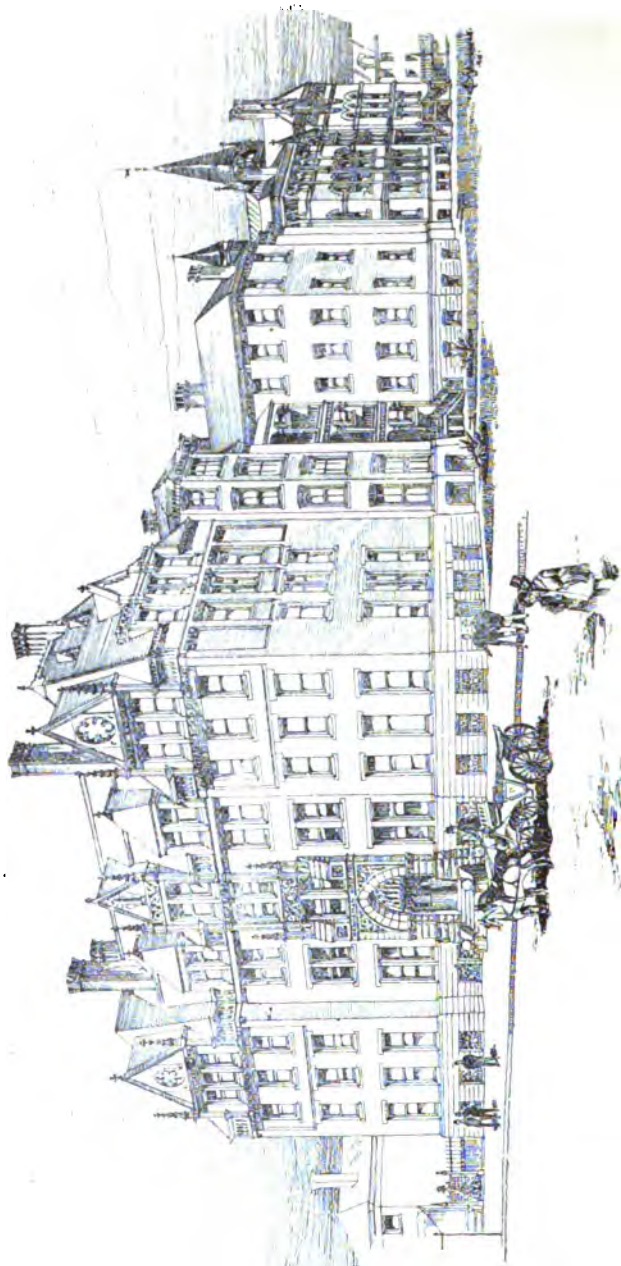
(d) *Vaginitis from Excessive Coitus.*—*Arnica* was prescribed with marked success.

(e) *Inability to Lie On the Right Side.*—This is a valuable indication for *mercurius* when occurring in pulmonary troubles.

(f) *Cholera-like Cramps with Diarrhœa and Vomiting.*—*Dulcamara* in any potency, in the absence of special indications relieves.—*The Clinique*, September 15, 1890.

**TREATMENT OF LARYNGISMUS STRIDULUS.**—In a discussion before the Clinical Society of the Hahnemann Hospital, of Chicago, Dr. J. P. Cobb said that he had found chlorine water diluted with plain water to about the third potency to be invaluable for the temporary relief of the spasm in laryngismus stridulus. The homœopathic trituration of naphthaline also acts well as a palliative. *Calcareæ iod.* is a satisfactory remedy in cases associated with enlarged glands.—*The Clinique*, September 15, 1890.





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FRACTURES OF THE CRANIUM.

BY J. M. LEE, M.D., ROCHESTER, N. Y.

(Read before the Homœopathic Medical Society of the State of New York.)

I HAD expected to write a paper on the subject of cerebral surgery, but have been so pressed for time that I am unable to do more than report a few cases of cranial fracture. I will, however, consider the subject at our next session at Albany.

Within the last two years much advancement has been made in brain surgery, yet it is still in its infancy. We are not able to diagnose, treat and prognose this class of cases with anything like the accuracy that careful study will yield. I believe it is the duty of all who have had any experience, to report their cases, and thus contribute what they can to this new and broad field of research. The failures as well as the successes should be given to the profession. The one serves to stimulate and encourage the conscientious student, while the other holds in check the over enthusiastic. Scarcely has there been a branch of surgery which has not been more or less abused by a class of men whose patients always have reflexes corresponding to their latest notion. But to return to our subject:

Let us consider some of the conditions which are the result of cerebral injuries. Convulsions are among those most frequently observed, and the following cases are reported to illustrate how prompt and permanent is the relief obtained by the proper treatment.

CASE 1.—This case is of interest because, notwithstanding the

unmistakable depression of the fractured bone, the convulsions did not appear until two months after the accident.

Adam Stevens, aged 15 years, of healthy parentage, entered the Rochester Homœopathic Hospital July 19, 1890, and gave the following history: He was perfectly well until four years ago, when he fell from a tree, and sustained a depressed fracture of the cranium about one inch above the right frontal eminence. Although he was unconscious several hours, he apparently made a good recovery. Two months later he was taken with a severe pain in the head, and convulsions soon followed. They always commenced in the left side of the face and the left arm, then they gradually spread over the entire body. The only premonitory sign of these attacks was that for about two minutes before each spasm the patient would turn in a circle, always going to the right. His appetite and general health were good. He was very impatient, and excitement would always bring on a convulsion; frequently he would have five or six a day, then they would cease for a day or two. There were no pupillary changes.

I decided that the depressed fracture which the boy had sustained at the time of the accident had been maltreated, and that an operation would relieve him. The patient was etherized, and the operation performed in the usual manner. A piece of depressed bone one and one-fourth inches in diameter was removed. He made an uninterrupted recovery, and has remained well to the present time.

CASE 2.—Charles Penrose, aged 26; a man of excellent health and a gardener by occupation. August 10th he was struck with a stone on the left side of the head, just above the squamous suture and one inch posterior to the articulation of the greater wing of the sphenoid with the frontal bone. The blow caused him to fall, but he did not lose consciousness, and by the aid of a friend was enabled to walk to his home, one-half mile distant. Upon reaching the house his head began to pain him, and a feeling of faintness came on. A physician was summoned, who thought the injury a slight one; but before he left the house the patient had several severe convulsions, which were always preceded by contortions of the right side of the face. They then decided to bring him to the hospital, where I first saw him. At times he could talk and express himself intelligently, then he would become semi-conscious, and a convulsion would soon follow. The head was shaved and rendered aseptic. Nothing could be elicited from a careful digital examination except that pressure over the point of impingement would cause the muscles of the right side of the face to contract and the pupils to dilate. The patient was etherized, and an incision made beginning at the

anterior third of the superior curved line of the occipital bone extending anteriorly over the left parietal and temporal bones, just grazing the squamous suture, to a point one-fourth inch above the union of the sphenoid with the temporal. The scalp was turned back, and a depressed fracture six inches long exposed. The trephine was applied over the posterior portion of the left parietal bone, about two inches from the sagittal, and one and one-half inches from the lambdoidal suture. As soon as the button of bone was removed, arterial blood gushed forth freely. The bone at this point was badly comminuted, and eighteen small fragments were removed.

An irregular portion of the inner table, measuring one and one-fourth inches in length by one-half inch in width, was pressing into the brain, and had ruptured the middle meningeal artery. After removing this, the balance of the fragments were elevated and the ragged edges of the inner table trimmed. The wound was lightly packed with iodoform gauze, a portion of which was allowed to protrude to promote drainage. The scalp wound was closed with interrupted sutures of catgut.

For about forty-eight hours the patient remained in a semi-conscious state. The wound was dressed on the seventh day following the operation, when the temperature, which had been normal, rose to  $101\frac{1}{4}$  degrees. However, this subsided within forty-eight hours, and no rise followed.

He was discharged from the hospital, and has resumed his former occupation.

Case 3.—Jerome Albro, a laborer, was injured at the Leighton Bridge Works, on May 27, 1885. He was engaged in hoisting an iron girder, which weighed about six tons, when one of the chains slipped, and he was caught between the girder and a large channel bar, which lay upon the skids. Dr. Newton M. Collins was called and found the patient lying outside the shop with his head in a pool of blood. The hæmorrhage came from a scalp wound, which began one inch posterior to the mastoid process and arched upwards and forwards to a point one inch anterior to the helix. This portion of the scalp, integument and underlying tissues were torn away, carrying the entire auricle of the ear with them and leaving the bones bare as low as the angle of the inferior maxilla. The doctor packed the wound with styptic cotton and applied a bandage. This controlled the hæmorrhage, and the patient was immediately removed to his home. The same evening a consultation was called. We removed the cotton and stitched up the scalp wound with a drainage tube retained at its most dependent point. The left inferior maxilla was fractured across its angle and widely separated, which caused great deformity. Owing to the wild delirium of the patient at

night, the fractured ends of the jaw could not be retained in position by any ordinary dressing. We were obliged to take an impression of the entire jaw and fit a gutta percha plate. The superior maxilla was also fractured in the median line, but as there was no separation it gave us but little trouble. Hæmorrhage from the nose and ear, together with the patient's general condition, led us to suspect that there was a fracture at the base of the brain. He lay in a semi-conscious state during the day, with delirium at night, but if shaken and spoken sharply to would answer in monosyllables. Within a few hours we noticed paralysis of the muscles of the whole of the left side of the face. When an attempt was made to protrude the tongue, it would curve to the left side. The ball of the left eye was drawn to the inner canthus. The sight in the left eye was impaired, also the hearing in the left ear. The temperature rose to 102 degrees, and a profuse watery discharge from the left ear appeared to the extent of a pint in twenty-four hours.

It was now evident that there had been a basal fracture which traversed the petrous portion of the temporal bone, and that the paralysis of the muscles of the face was due to injury to the facial nerve in its serpentine course through the aqueductus fallopii. The abducens was probably injured in its passage under the posterior clinoid process into the cavernous sinus, which accounted for the paralysis of the external rectus muscle. The hypoglossal nerve makes its exit from the cranium through the anterior condyloid foramen and passes vertically upward under the internal carotid artery to a point opposite the carotid foramen in the petrous portion of the temporal bone. It is more likely that the nerve was injured at this point than that the fracture extended into the occipital bone. This, of course, accounts for the inability of the patient to protrude the left side of the tongue.

After the first week the temperature returned to normal and the delirium subsided. The patient's recovery was slow, and he required the doctor's attention from the 27th of May to the last of August. The paralysis of the face and eye have not improved any. The sight and hearing remain the same. He has never regained his general health, which I think is partly due to the nervous shock, and while he has sufficiently recovered to be around, he is not able to resume his former occupation.

THREE CASES OF SUPPURATIVE KERATITIS WITH ULCERATION  
TREATED SUCCESSFULLY, AFTER FAILURE WITH REMEDIES  
USED INTERNALLY AND EXTERNALLY, BY GALVANO-  
CAUTERY.

BY M. O. TERRY, M.D., UTICA, N. Y.

(Read before the New York State Homœopathic Medical Society, October 1st, 1890.)

OWING, perhaps, to the septic character of the inflammatory action in the cornea, I have failed in several instances in relieving various forms of ulceration of this delicate membrane. Although I would not recommend this treatment in every case of ulceration, I would not allow the disease to advance under remedies used internally and externally, to any great extent, without resorting to this somewhat heroic measure. 'Burchardt, in the *London Medical Record*, says: "The cocci of phlyctenular keratitis can be got rid of best by the galvano-cautery, after which irrigation with boracic solution and calomel insufflation." Gruening makes a practical suggestion: "In view of the fact that every one may not have a cautery battery at hand, a platinum probe heated in the flame of a Bunsen burner may be made to serve the purpose as well."

In looking over the cases reported in vol. 33 of the *Transactions* of this State, I am deeply impressed that the cases therein reported of "Traumatic Ulcer of Cornea" would have been treated as well, and I believe better, with the cautery. I should certainly omit poulticing, as it softens the tissues and permits the more ready entrance of the pus corpuscles into the healthy portion of the cornea. This same principle of not poulticing, is equally objectionable in carbuncles, where the softening produced by poulticing causes the spread of the septic inflammation. Then, again, the cautery does not require the skill of an oculist who performs Saemisch's operation of transfixion of the cornea, as any physician with a steady nerve and careful hand can do it. Dr. A. B. Norton's remarks on the paper referred to in the *Transactions*, in which he recommends the cautery, seem to be confirmed in the three cases presented.

The following cases will illustrate the procedure:

Mr. R., æt. 53, came to me with a rapidly-spreading ulcer of cornea. By occupation he is a farmer, and he is in a perfect state of health. Gave him remedies used for destructive inflammation and a cocaine eye-wash containing boracic acid. As no improvement was

observable, and the pain and photophobia continued, I applied to the ulcer, having first used cocaine, the flat surface of a cautery blade. This was repeated in five days. The patient was given a 4-per cent. cocaine wash, and weak cerate of yellow oxide of mercury, to be used once daily. Recovery was rapid.

CASE II.—Mr. A., æt. 29, a strong athlete, over six feet in height, a farmer, feels well in every particular. Tried remedies for three days; no improvement in ulcer, which was spreading and painful; inflammation of cornea quite marked. The character of the ulcer was septic, of the phlyctenular variety. Cauterized it, using cocaine. Repeated in three days. Gave internally merc. cor., iodide of sulphur, iodide of arsenic, and bell., at various times. Rapid recovery ensued.

CASE III., was a puny boy, eight years of a age. He was given tonic treatment, nourishing food, and remedies for the phlyctenular ulcers; calomel, cocaine, eserine, and cerates, were also used. No improvement. Quite a struggle to cauterize, but succeeded fairly well. Repeated at intervals of five days until he had been cauterized three times. Recovery steady under the ordinary remedies named and antiseptic cerates.

Of itself, this treatment would, perhaps, fail, but it is *very* important as *one* of the auxiliary measures, for two reasons: To destroy the septic nature of the ulcer; secondly, to stimulate it to heal.

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## THE COLON DOUCHE IN ORIFICIAL SURGERY.

BY A. L. MONROE, M.D., LOUISVILLE, KY.

(Read before the American Association of Orificial Surgeons, September, 1890.)

My attention was first called to the use of a tube for the purpose of flushing the colon with warm salt water, in 1888, by Professor E. H. Pratt. I afterwards found it to be the "formula" for obtaining everlasting health that was sold by a certain Dr. Hall, of New York, under the promise of profound secrecy.

It has become indispensable to me in the practice of orificial surgery, and in the treatment of chronic constipation, chronic diarrhœa, chronic dysentery, and melancholia. Hence, I am not writing for any of my colleagues to do without it if I can direct their attention to its use.

The instrument employed in flushing the colon consists of a soft rubber tube from two to three feet long, made to fit in the rectal tip of an ordinary bulb syringe. The technique of its use is about as follows:

A teacup of salt is poured into about a gallon of hot water, which loses about ten degrees of heat *en route* through the tube. The patient is placed upon his left side, with a pillow under the hips, as in the knee-chest position; the tube is greased over its entire length, after which the tip is introduced into the rectum. It is then gradually inserted; about two bulbs full of water are injected to each inch of progress, until its whole length is in the large bowel. By this time the salt water is about exhausted, and the large bowel distended to its utmost capacity. The patient by this time is suffering from severe griping. This can be modified by turning him over face down to the right side, and having him retain the water as long as he can without too severe suffering. During the hour following the operation he has several profuse discharges, which seem to be less debilitating than those following catharsis.

These injections are useful :

*First.*—In orificial surgery, when it is not desirable for the patient to have an action of the bowels for from three to seven days after operation. In these cases, two should be given before and one after operating; the first, two days previously; the second, early the morning of the same day, and the last from three to seven days after operating—depending upon the nature of the case.

*Second.*—Many colons are chronically impacted, lined with indurated faecal matter, like an old stove, when the ashes of many winters form clinkers on its side that have to be chiseled off; these impacted colons present a small canal at the side or in the middle of the impaction through which the faeces must pass.

Such patients always have to liquefy their stools by drugs each time they obtain an action.

*Third.*—In chronic catarrh of the large bowel, exhibiting symptoms of chronic diarrhoea, or chronic dysentery, or by the free discharge of mucus with the stools, even though they consists of round hard balls.

*Precautions.*—The rectum should not be filled too full at the start, as it will produce urgent desire for stool too soon, and the injection cannot be completed satisfactorily. The treatment should be applied on an empty stomach or nausea and vomiting will be apt to supervene.

It is well to avoid too full an injection at first. My plan, except when preparing for operation; is to use about three quarts the first time, and gradually increase to the full capacity of the gut; my first two injections are usually given at intervals of three days, and

about four succeeding ones at weekly intervals. The treatment seems to improve the whole patient when it is indicated. The complexion begins to clear up, weight increase, and bowels that were asleep are awakened to renewed life and energy. Melancholy patients become more cheerful, for you know the colon is thought by many to be the place to hunt for the ætiology of melancholy. The whole circulation of the *prima viæ* improves, and nutrition is, of course, affected in a like degree. Where catarrh exists, such drugs as *hydrastis* or *pinus Canadensis* can be substituted for the salt. Should it be desirable to increase the solvent power of the solution, sulphate of magnesia or glycerine may be substituted, though the latter in small relative amount.

The good effects of the treatment may often be augmented by the free use of hot water, by the mouth, during the continuation of the treatment, especially the day and night before each injection, thus flushing the waste-pipes all over the body—the skin, the kidneys, and the bowels—and softening the *fecal* matter in the bowel; for I believe that such patients as this treatment benefits are often the subjects of a sort of chronic toxæmia, due to the constant re-absorption in small quantities of effete matter that is not excreted promptly enough.

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### STOOP AND ROUND SHOULDERS—THEIR RELATION TO CHEST-EXPANSION AND PHTHISIS PULMONALIS.

BY EDWARD R. SNADER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of Pennsylvania, September 17, 1890.)

It is a well-known clinical fact that the upper portion of the lung structure is first attacked by phthisis pulmonalis. In about 98 per cent. of cases the ravages of the disease are first noted at the summit of the chest. Apical solidification is considered to be one of the clinical laws of phthisis. Numberless theories have been evolved to account for the special predilection as to location evinced by the dread disease. The view most reasonable is that the summit of the lung is first and most frequently attacked by the germ agent or anatomical elements that induce the tissue changes incident to pulmonary phthisis, because the apices are the least used portions of the lung structure. Lack of functional activity is, therefore, considered to be



the special predisposing factor in the selective affinity shown for the summit of the lungs by phthisis pulmonalis.

That the idea of the quiescence of the apices particularly, and sometimes of other portions of the pulmonary parenchyma is held by many to be a cardinal causative condition for the production of pulmonary phthisis, is evidenced by the theories advanced by practical men to account for the lack of use, or limited use, of the apices and other parts of the lungs.

A view, apparently in opposition to the one under discussion, was promulgated by a German observer who had had a prolonged and extensive experience with phthisical patients in hospital practice. He stated that an overwhelming percentage of phthisical patients possessed abnormally large lungs. This opinion had been reached after years of careful study, research and observation, and he contended that numberless post-mortem examinations confirmed his view. Another important fact was noted in the dead-house observations: The large lungs were nearly always associated with small hearts. The fact of large lungs existing in phthisical patients is no evidence that large lungs are the special predisposing cause of the disease. The whole pathological picture must be viewed, not single portions. I could accept the fact of extra large lungs in the phthisical dead, if it were proven indubitably, without embracing the theory drawn from the fact. The German observer's cases had large lungs and small hearts. Apparently, the little hearts were at the bottom of the trouble, not the big lungs. The hearts were too small for the lungs, not the lungs too large for the body; for, inferentially at least, it can be argued that the small heart could not supply the large lungs with a sufficient amount of nutriment, and, consequently, the lungs were deficient in functional activity and a large area practically at rest; and it is *lung rest* that many regard as a specially powerful predisposing factor in the causation of consumption.

A distinguished doctor of this city goes further than the German observer. The latter thought phthisical lungs were large; the former believes that nearly all moderns have too much lung capacity. According to Dr. Mays's view, nearly the whole civilized race are large-lunged. These huge breathing-bags were bequeathed to us by our aboriginal forefathers, whose pursuits demanded greater lung capacity than we need in our day. It can be inferred from the doctor's views that successive generations of wild life and heredity only increased the lung volume. Our large lungs, then, are bequeathed us by the breezy plains and sighing forests, moving monu-

ments to the fleet-footed game our forefathers ran down and feasted upon. We have not lived long enough, are not far enough removed from ancestral influence, to have reduced our lung space to modern needs.

I need not devote much time to refute this view. It seems to me impossible and illogical to dogmatically fix the limit of the proper size of the lungs. To delimit nature is a difficult task, and nature has apparently performed her work well by providing sufficient lung capacity for emergencies. Man can live at an extremely high altitude and use every fraction of an inch of his lung space. If the pulmonary parenchyma were simply sufficient for ordinary needs, an unusual demand for air would result in death, and every pneumonia would kill, and even a trifling bronchitis would end fatally. Running, exertion or laborious pursuits would be impossible. To say that the lungs of man are too large is not sufficient. So long as their proper size is not provided for, it seems wise to accept our large lungs, if we really have them, as a gift of beneficent nature. It is better to accept nature's make-up than a theory. The conclusions drawn from the large-lung theory are that many of the cells are not used, and that the rest thus induced predisposes to phthisis pulmonalis.

I certainly believe that lack of functional activity in the lungs predisposes those organs to disease, but I cannot see how a theory of unnecessarily large lungs helps greatly toward a solution of the problem of how pulmonary quiescence is really caused. It is reasonable to suppose that undue lung rest predisposes to lung disease, for it is a fact well known that if organs are unused, or only partially used, their functional activity is lessened, and if their functional activity is lessened they are supplied with less nutriment, and if they are supplied with less nutriment they fall below physiological par, and when they fall below physiological par the organs are more susceptible to disease and disease influences.

I want to consider a potent cause of lung rest—stoop or round shoulders. Any one who is stoop- or round-shouldered is not a normal position for using the lungs freely and readily. The weight of the shoulders, overhanging the thorax, acts as a mechanical bar to the easy expansion of the upper portion of the chest. This bad bodily habit ultimately leads to disuse of many of the muscles of respiration, and in consequence the summit of the chest remains nearly, if not quite, quiescent.

Stoop or round shoulders are, I know, nearly universal, and phthisis pulmonalis is not. Can it then be argued that there exists

any sort of relationship between a bad bodily habit and the dire disease, consumption? To my mind there are a number of very good reasons for believing that stoop or round shoulders are a strong predisposing cause of phthisis pulmonalis.

*First.*—The summit of the lungs are first and most frequently attacked by phthisis. Rest is a causative factor. At the summit of the chest is the quietest part of the lung structure. The causative agent of phthisis seeks the tissues least able to resist disease.

*Second.*—The frequent presence, at the beginning of a physical examination, of adventitious sounds at the summit of the chest, the sounds disappearing after a few deep respirations, the respiratory murmur disclosing no abnormalities. These sounds, it appears reasonable to suppose, have precisely the same origin and mechanism as those frequently found when we auscultate a patient who has been long recumbent, as in typhoid fever. The cause of the râles in both instances is lung rest, and the agglutination of a number of air-vesicles.

*Third.*—The greater the disease existing at the apex the greater the abeyance of movement. If disease lessens functional activity, lessened functional activity ought to predispose to the disease that lessens it.

*Fourth.*—The almost universal immunity from phthisis among emphysematous patients. The dilated condition of the air-cells in the latter disease prevents or militates against solidification. Disease in emphysema keeps the air-cells open, and healthy activity of the apices keeps the vesicular structures distended, the blood circulating freely, the tissues properly nourished; and, therefore, active apices, from health or disease, tend to prevent phthisis pulmonalis. A French doctor attempted to produce emphysema in order to save his consumptive patients.

*Fifth.*—The effect of respiratory gymnastics upon a diminished summit expansion due to solidification. The physical signs showing solidification of the apex are considerably and often greatly modified for the better by exercise leading to a re-establishment of proper breathing at the summit. The general symptoms, as well as the physical signs, show often such an improvement after the inauguration of correct respiration that it leads to the opinion that had the vital capacity not been seriously diminished (and many air-cells permitted to go unused) by such bodily habits, the disease would have not been able to obtain a foothold, or, if a foothold had been gained, it would have not been possible to hold its first vantage.

*Sixth.*—Even where no actual lung lesion is found many cases of anæmia and other diseases are sometimes quickly restored to health by gymnastic exercises directed *alone* to a proper expansion of the superior portion of the chest. If amelioration of general health follows increased summit expansion it seems reasonable to suppose that diminished summit expansion is quite capable of giving rise to a systemic condition below par; in other words, would predispose to disease, and particularly to a disease that by preference attacks the lung apices.

*Seventh.*—The abnormal conditions of the bloodvessels in the apices in the stoop-shouldered predispose to disease. When the air-cells are only partially filled with air the vessels supplying the cells are lessened in their area of distribution. The air-cells below, actively carrying on the function of hæmatosis, press upon the cells of the quiescent summit and further diminish the amount of air in the vesicles and crowd and compress the bloodvessels. Now what happens? If the heart is strong the obstruction offered by the crowded vessels is overcome. In time, however, the vessels become relaxed, and the returning blood in the veins becomes more or less stagnant, offering still further obstruction to the circulation, and a slight œdema occurs. The small amount of air in the vesicles is further diminished in quantity by the swollen vessels, narrowing the lumen of the cells, and finally the walls of the air-cells, soggy with moisture exuded from the vessels and, almost, if not entirely, airless, collapse and fall together. Every respiratory movement transmitted from the active cells below and about the quiescent vesicles causes attrition of the approximated cell-walls, irritates the epithelial lining, causes a proliferation of the epithelial cells, and an apical catarrh, a catarrhal pneumonia is inaugurated. Now, if the distended vessels from special exertion or from sheer weakness and lack of tone from long-continued congestion exude blood the fluid extravasates through the unused tissues, increasing the solidification, and leading to caseous degeneration of the results of the hæmorrhage and of the intra-vesicular inflammation. Tubercle bacilli may be present or not. That a considerable degree of moisture (it may be only a slight increase over the normal amount) is present at the summit of the chest when the apices are not freely used I am quite confident. I base my belief in the existence of this physical condition, under the circumstances I mention, upon the fact of the frequent discovery of extremely fine, moist and dry

sounds at the apices at the beginning of many examinations, in which no actual named lung lesions are discoverable.

*Eighth.*—The discovery during the course of systematic examinations of the chest of considerable areas of collapsed lung tissue at the thoracic summit. I have determined the solidification incident to the collapse to be neither tubercular nor catarrhal pneumonic by the speedy restoration of the normal percussion note and normal respiratory murmur following the carrying out of systematic respiratory gymnastics. These cases presented none of the symptoms of phthisis, and some not even the clinical phenomena of an ordinary bronchitis. I have known the respiratory murmur to return to its normal characters as to pitch and quality, after having presented all the evidences of solidification, and the chest expansion to be greatly augmented after only two weeks' exercise. The respiratory murmur assumed its normal characters and the percussion note its vesicular quality when the stoop shoulders had been corrected and deep breathing had been practiced. Had such cases been examined by me in the early years of my experience with physical diagnosis I would have diagnosed either fibrosis or non-progressive phthisis. It appears to me that the fact of the occurrence of these areas of collapse and a diminution in the expansion at the summit demonstrates forcibly that stoop shoulders are capable of inaugurating all the phenomena I have indicated.

*Ninth.*—It is a fair assumption that some of the benefit derived in the treatment of phthisis by compound oxygen and other inhalations is due to the increased expansion of the air cells, and not all to the medicaments employed. Physicians who employ inhalations take special pride in mentioning the increase in the vital capacity as an evidence of the efficacy of their treatment when that particular improvement is, to my mind, really due to the practice of deep breathing.

I believe, then, that lung inactivity is a predisposing cause of consumption and that the special localization of phthisis pulmonalis at the lung apices finds its most reasonable explanation in the fact that the naturally diminished movements of the summit are morbidly intensified and rendered powerful for evil by faulty positions of the shoulders.

Let me recapitulate my reasons for this belief very briefly.

1. The natural and acquired quiescence of the apices.
2. The presence (frequently) of adventitious sounds at the summit, the respiratory murmur maintaining its normal characters.

3. The abeyance of chest movement when the upper part of the lungs are only slightly used.

4. The immunity from phthisis shown by emphysematous patients.

5. The apparent lessening of the area of the lung solidification after the inauguration of upper chest respiratory gymnastics.

6. The effect of the correction of stoop or round shoulders upon the general health.

7. The turgid condition of the bloodvessels at the apices induced by the enforced quietude of cells by reason of the limited expansion due to stoop shoulders.

8. The presence of areas of collapsed lung tissue at the summit in cases of pronounced stoop shoulders.

9. The increased vital capacity following forced breathing while undergoing treatment with inhalations.

It seems to me that these several reasons furnish sufficient ground for believing, not only that the quiescence of the summit is the cause of the special affinity of phthisis for the apices of the lung, but also that stoop shoulders are a strong predisposing factor for the development of that dread disorder.

Let me answer a few possible objections that may be urged against the views I have announced. Is not the universality of stoop and round shoulders and the relative infrequency of phthisis, an argument against the view that stoop shoulders are a predisposing cause of phthisis pulmonalis? I think not. Consumption requires for its development at least two, and possibly three, factors in operation at the same time; first, a special soil; and second, the tubercle bacillus, or irritability of epithelial elements, and lung quiescence. Unused apices furnish a special soil for the development of either catarrhal pneumonia or tuberculosis, or both, the exact disease being dependent upon special circumstances. Another point to be taken into consideration is, that although most persons are stoop or round shouldered, their apices are not always quiet. Their occupations, exercise, or occasional extra demands for more air than is used in ordinary respiration, does not permit the summit to remain continuously inactive, and hence the vessel torsion, the cedema, and the collapse are occasionally relieved.

Have I ever found lung consolidation incident to phthisis in individuals whose apical expansion was good? Yes; I recall, without referring to records, three instances, all very muscular men (two were athletes), in which the chest expansion at the summit and elsewhere

was enormous. In all three cases I found positive signs of lung consolidation. In one, a machinist, who rejoiced in his strength, and daily lifted heavy burdens, I found the solidification at the outer portion of the left apex, about an inch below the clavicle. He used the right arm much more extensively than the left, and there was, therefore, relative quiescence of the left summit. In the other two the solidification was found in the central portions of the chest, a little below the bifurcation of the primary bronchi. The position of the solidification in these two instances (I excluded syphilis) led to the inference that the lung-tissue was involved in this particular situation in consequence of direct inhalation of infecting agents through the bronchial tubes.

Have I ever found phthisical solidification at the base of the lungs? Yes. I recall two cases, both in females, who laced tightly, and who breathed freely with the upper portion of the lungs.

Does not the fact that women who breathe with the upper portion of the chest, have phthisis quite as frequently as men, invalidate the idea that quiescence of the apices is a predisposing cause of consumption? I do not think so. If supracostal breathing be characteristic of women, as is believed and taught by physiologists, it is a clinical fact, according to my individual observation, that, during ordinary respiration the supracostal method is seldom used, and therefore there is induced a relative quiescence of the lung apices; indeed, if the physiologists be right, the summit abeyance of movement is greater relatively in women than in men. If, on the other hand, women should breathe by the abdominal method, as is contended by some authorities, there still exists a relative quiescence of the summit, despite the fact that women (as I have repeatedly noted) more readily assume the supracostal style of respiration than men, because of women's smaller lungs, weaker muscular system, sedentary habits, and confinement in-doors. I am not endeavoring to prove that a quiet summit is the cause of all cases of phthisis. I am simply trying to show that stoop and round shoulders are a strong, a prominent, predisposing factor for the inauguration of a chain of changes in the apices of the lung structure that result in the symptomatic phenomena and the physical evidences of the disease we know clinically as consumption.

The considerations I have recorded in this paper lead me to believe that lung quiescence is a predisposing factor for the production of phthisis; that apical quietude determines the special primary localizations of that disease; that any measures of prophylaxis against

or treatment of consumption that does not contemplate the restoration to functional activity of little used or unused air-cells is futile, unscientific, and purely palliative; that as a prophylactic against general ill health it is our duty to instruct our patients how to overcome this bodily deformity.

How can stoop or round shoulders be overcome? There are several methods of exercise by which it can be accomplished. If it be remembered that our principal object is not simply to overcome the deformity for the deformity's sake, but because it acts as a barrier to breathing freely with the apices, it will be seen that it will be necessary to practice deep breathing in connection with any movements designed to correct the faulty body habit. There are three methods by which the air vesicles can be distended. First, by raising the shoulders, bringing into play the extrinsic muscles of respiration; second, by movements of the abdominal muscles and diaphragm, filling the air-cells, apparently from below upwards; third, by filling the air-cells gradually and pushing the lung structures out against the chest-walls. All three methods are of value. But, at first, it is my endeavor to secure active apices. I advise my patients, the first thing in the morning, when they have upon them only their night robes, to stand as nearly erect as they can, raise their arms vertically above the head, the muscles being slightly tensioned, and then allow the outstretched arms to fall slowly, almost by their own weight, keeping them inclined backward. This motion is repeated several times at first, and the time for the exercise is gradually lengthened. Later I have the patient inspire while raising the arms, and expire while allowing them to fall.

Another movement is the use of a pole about a foot longer than the lateral reach of the two arms outstretched, and, grasping the pole in front of the body, with the arms stretched nearly to their limit, bringing the pole over the head, and letting the arms and pole fall gradually until the pole strikes against the back. This movement is also, after skill is shown in its performance, accompanied by forced inhalation and exhalation.

Causing the arms, the muscles, being somewhat tense, to describe a complete circle, from behind forward and *vice-versa*, with the outstretched arms a little inclined above the level of the shoulder, is a procedure of value; as is also a side movement of each arm describing a segment of a circle.

Raising the shoulders and rotating the head of the humerus in the



socket, and making the backward movement pronounced, is a good one.

Swaying the body from side to side, the arms hanging limp and swinging from the body only, tends to develop the abdominal and intercostal muscles, aids free diaphragmatic movements, and gives greater mobility to the shoulders.

All these movements, and many more, are applicable for the purpose of correcting the special deformity under consideration. To all are added breathing movements. All are modified to suit individual needs. I have not, in any case, employed violent exercise. I do not care to have weights, even light ones, used while the movements are carried out.

I regulate the amount of exercise altogether by the fatigue induced. I always stop short of pronounced fatigue. Many patients will complain of dizziness during the exercise, and will desist on that account. I do not stop the exercise for this symptom (due probably to an altered cerebral circulation), but lessen the number of movements, gradually increasing them and finally passing the point where vertigo was at first produced.

I have my patient practice deep breathing, particularly of the upper portion of the chest, sometimes without conjoining it with exercise.

Where the stoop shoulders are pronounced, I forbid high pillows. I recommend very strongly indeed, in some instances, the taking of lessons in singing, flute and cornet playing. Some cases require a long time before an improvement is observable, and this is particularly noticeable in persons over forty years of age.

I also enjoin voluntary anterior, posterior and lateral movements of the abdominal muscles. I insist that women shall wear loose corsets, and in some who have apparently an insuperable objection to anything like voluntary exercise, I have read as many words as they can with one breath. They occasionally become interested in the performance, and involuntarily straighten up and take deep breaths. I then have a text from which I can preach to advantage.

The movements I have here given, or others that are specially adapted to special cases, will in most cases correct stoop or round shoulders, if persisted in. Many of the Swedish movements are specially adapted to aid in the cure of this deformity.

## AN ONOSMODIUM VIRGINIANUM CASE.

BY HORACE F. IVINS, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania, Sept. 18, 1890.)

Mr. —, aged 46, consulted me, at the suggestion of Dr. C. M. Brooks, December 30, 1885. His chief complaint was headache. The following history is taken principally from the record made at the time.

He has had headaches day and night for the past ten years, frontal, but centres chiefly over the left eye and in the left temple; worse in the dark and lying; use of eyes, lights and noises do not annoy. The pain is usually a constant, dead, dull ache, but about four or five times a month it becomes almost unbearable. Sleep very miserable, formerly but about one and one-half hours nightly, now a little better: can sleep a little during the day, when he can fall asleep more easily than at night, because it is light; the pain is less and day-noises interrupt the flow of thought. Since the pain began, ten years ago, there has been but one instance when the dull aching ceased. It left suddenly one evening during the winter of 1882, and did not return until the next morning, since which it has never ceased. There was much mental strain preceding the onset of the headache.

Mr. — is tall, finely developed, mentally as well as physically, weighs about 200 pounds, and apparently the picture of health. His suffering dated from many sleepless nights and active days, during which time he was inventing and completing a complicated and extensive piece of machinery.

The symptoms pointed to a very considerable nervous deviation, and to the eyes as a probable cause of the continued aggravation, augmented, perhaps, by a long-lasting naso-pharyngeal catarrh. He was wearing R. +  $\frac{1}{2}$  s. and L. +  $\frac{1}{2}$  s., for reading and writing only. The ophthalmoscope revealed no irritation of the retina or other pathological change, but made evident the presence of a moderate hypermetropic astigmatism, which was confirmed by the shadow and subsequent tests. Vision equalled  $\frac{3}{8}$  each eye, and was slightly improved by convex  $\frac{1}{8}$  s., but still more by weak cylinders. Homatropine revealed the following refractive error: R. +  $\frac{1}{4}$  c. ax.  $80^\circ \subset$  +  $\frac{1}{8}$  s.; L. +  $\frac{1}{8}$  c. ax.  $105^\circ \subset$  +  $\frac{1}{8}$  s. The combination prescribed was R. +  $\frac{1}{4}$  c. ax.  $80^\circ \subset$  +  $\frac{1}{2}$  s.; L. +  $\frac{1}{8}$  c. ax.  $105^\circ \subset$

+  $\frac{1}{2}$  s., for constant use; this gave good vision for reading, and  $\frac{2}{3}$ ths for distance. Although the compound cylinders gave some relief and made all close work easier the headaches were not sufficiently modified to justify the statement, "a grand success," yet the glasses proved so satisfactory that they could not be discarded.

It was early thought best to turn our attention to the catarrhal condition. Mild local treatment was instituted and constitutional remedies given; the latter consisted chiefly of hamamelis, merc. viv. and jod. rub., sang. can. and nitrate, bry., nux v., rhus, puls., phos., gels., ignatia, sul., iris, stram. and hydrast. can. The catarrhal treatment gave decided relief to the naso-pharynx and slightly modified the head symptoms, but was not sufficient to cause great improvement.

In July of last year I determined to try the efficacy of the tincture of *onosmodium virgin.* on No. 35 pellets. As this remedy had so often aided the use of lenses when not entirely satisfactory I resolved to try it here, but as the symptoms were somewhat at variance with the recorded symptoms of *onos.* more doubt than faith accompanied the prescription. The directions given were: "Four pills every night and morning for three days should no relief be noted before the end of that time, otherwise to be discontinued until the symptoms again grow worse or until improvement stops, when one dose is to be taken." I considered these precautions necessary as I had so often seen this remedy produce drug aggravations in this class of cases. Mr. ———'s subsequent statement was: "In the evening, during a severe attack, I took four pellets; within half an hour the pain left entirely. I repeated the dose the next morning and evening, but as the pain did not return I discontinued the medicine." His statement on the 6th of this month (September, 1890) was: "Since that time I have had no chronic pain, but have probably taken the medicine eight or ten times for acute attacks, and each time the *onosmodium* gave prompt relief, the pain invariably disappearing within twelve hours; I generally sleep about six hours nightly."

It may be argued that this one case does little in the way of demonstrating the usefulness of *onosmodium*, but as I have seen nearly all of these symptoms repeatedly relieved during its administration in other cases since that time, I feel quite safe in recommending the drug for the symptoms most prominent in this case, and when prescribed, always anticipate decided success, and, too, after a few doses, as the remedy acts promptly if at all.

*Recapitulation.*—Constant dull headache, chiefly centred over the

left eye and in the left temple; at times, so sharp as to be almost unendurable; pain not aggravated by light, noises or use of eyes, but always worse in the dark and lying down; all of which, though somewhat relieved by the use of compound convex cylinders, and the relief to a naso-pharyngeal catarrh, were not cured until three doses of onosmodium tincture had been taken at twelve-hour intervals, the chronic dull pain never returning, and the acute suffering seldom recurring, and always soon relieved after a repetition of the drug.

Although a remedy of great importance, onosmodium has received comparatively little notice; there are few clinical reports, and even Gentry, in his first and second volumes, seems to have neglected it entirely, judging by his lists of remedies noted at the beginning of each volume. On account of this scarcity of notice, I quote some points bearing upon the case, just recorded, making my selections from Allen's *Handbook*. Under "Head," we read: ". . . *Frontal pain over eyes, worse over l. eye, over bridge of nose, on l. eminence; in r. eminence, changing to l., where it remained; running back into neck; heavy, and the same pain in temples and mastoid region. Pain in l. temple, sharp, darting, in l. temple, darting, throbbing in l. temple . . . Dull, heavy pains in l. side and over l. eye, extending around to back of head and neck, worse from movement and jar, forcing her to go to bed, when they were better after sleep, but returned soon after waking. Occipito-frontal pain in morning on waking. . . .*"

Under "Clinical:" "Dull headache, worse in occipital region. usually extending down nape or over one side of head, generally; with the headache, usually dizziness, and sometimes nausea, and either preceding or following the headache, pain in or over the corresponding eye, with stiff, strained sensation in the eye, worse reading or near vision. . . ."

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### IS AMALGAMATION POSSIBLE?

BY S. LILIENTHAL, M.D., SAN FRANCISCO, CAL.

(Continued from October Number).

"*Chloride of Lime* is known and used as a deodorizer and disinfectant. *Kalium chloricum* was formerly considered a specific for diseases of the mucous membranes of the mouth or fauces, but it is a dangerous drug and inconstant in its action. *Acidum hydrochloricum* is indicated in gastric disorders. Acidity of the contents of

the stomach, mostly caused by butyric and other fatty acids, does not only contraindicate the use of hydrochloric acid, but is very often benefited by it. To prepare, in febrile diseases, a refreshing draught, hydrochloric acid may be used, as it also aids digestion and thus renders all other acids unnecessary."

What would Schüssler do without his *kali muriaticum* and *natrum muriaticum*, and there is hardly a remedy which I prescribe oftener and with more confidence than this *kalium chloricum*. In relation to the use of muriatic acid in adynamic fevers, we must look for the stage that indicates it and then it will be found that there is a vast difference in the symptoms which indicate muriatic, phosphoric and sulphuric acids. In all the chlorides we find a scorbutic state of the blood prevailing. Dunham speaks highly of chlorine in spasm of the glottis.

"*Bromides* and epilepsy go hand in hand, as they stop more or less the fits, as long as the drug is taken, which should always be done under the supervision of the physician. They may also be used in many affections of the nervous system, as chorea minor, neurasthenia, insomnia, vomiting of pregnancy, whooping cough and in convulsive disorders."

Abused by the old school, it is too much neglected by the new school, a fault which we meet in our practitioners also in relation to quinine and calomel. All the halogens produce pseudo-membranes and all show specific effects on the glandular system. I always dreaded pneumonia of the lower lobe of the right lung, till I learned the symptom of bromine: "It seems as if he could not get enough air in the chest," which thus differentiates it from phosphorus and tartarus stibiatus. The heart symptoms of bromine deserve close study; and, again, in comparison with phosphorus scrofulosis is another hint for brom.

"*Iodium*. In tertiary syphilis and scrofulosis, habit keeps up its use, for it is often given when other treatment would do better. The internal use of Lugol's solution may be considered obsolete. Externally applied it fails in pleuritic exudation or in glandular induration, but injected into cavities and joints, beneficial results may be expected. Iodine preparations hardly ever do any good in tuberculous affections, while in other scrofulous affections it may be tried in combination with iron, cod-liver oil and good hygiene."

For us, true croupous affections anywhere in the respiratory organs are the key-notes for iodium, but with the caution not to change the

remedy too soon or failures will follow. Slowness, a kind of indolence is characteristic of iodium and its salts, and torpid scrofulosis far more its field of action than florid scrofulosis. Marasmus and cachexia, a desire for food, which is not assimilated, call for it. The large doses of the bromides and iodides, which the old school so liberally prescribes, may be necessary by their antidotal relations to drugs and diseased states; and when one of us intend to give it on the same basis, he could not expect any result from potencies; but is there ever any necessity for such deviation and cannot we do equally well with strictly individualized antipsoric treatment. Here, especially the study of Grauvogl's constitutional treatment will be well rewarded.

*"Fluoric acid* in inhalation is recommended in phthisis tuberculosa and it is said to aid nutrition, and cause disappearance of the bacilli and less cough."

With us calcarea fluorica takes its place and it is certainly a splendid drug in diseases of the bones and periosteum, with relief from cold applications. In my practice calcis murias did me better service than the fluoride of calcium, but it is well to keep both in mind in the treatment of bone felons. Morvan's disease may be checked by their use. As fluoric acid increases muscular endurance, we may thus perhaps understand its action in wasting diseases.

*"Azote and nitric acid* and laughing gas, amyl nitrite and nitroglycerine are recommended in angina pectoris (but not when caused by aortic insufficiency) and in epilepsy. Nitric acid is useless when internally given. For external use in warts, condylomata or phagadænic ulcers, it is superseded by other means."

How disdainfully our glonoine is treated, which certainly produces sudden and violent irregularities of the circulation; how many throbbing headaches were quickly relieved by this gift of our own Hering, and in heat fever it has hardly an equal. Its difference from belladonna is especially shown in puerperal convulsions from albuminuria; it has not the bright redness of the deadly nightshade, rather a darker shade prevails from the oppression in the brain overloaded with effete matter. No use for nitric acid! Let Penzoldt again study Grauvogl; and in our own practice nitric acid was always highly esteemed for its anti-hæmorrhagic qualities, especially in typhoid fever. Phagadæna means more than mere local death and the internal and external use of this acid will stop the

destructive process, though there are other means to do it, hence the necessity for strict individualization.

"*Petroleum* ought never to be taken internally nor used externally, as it causes gastro-enteric and central nervous symptoms; but paraffine, vaseline, cosmoline are in daily use, as they decompose not so easily as animal fat."

Petroleum is a poison, hence potentization is necessary to render it useful. In sea-sickness it has been tried, but I acknowledge failure. It is one of the few drugs that give us the sensation of coldness about the heart. Those who work in coal-oil often suffer from eczematous eruption, with fearful itching and burning, and just in similar cases the internal use of petroleum has earned many praises from suffering and disgusted patients.

From page 74 to 144 Penzoldt treats of chemicals which are to a large degree of very little use in homœopathic practice. Soporifics can mostly be dispensed with, and antipyretics are of doubtful use, even according to some good old-school authorities. Antipyrine certainly deserves a thorough proving, as its beneficial action in neuroses and in rheumatic affections cannot be gainsaid, and salicylic acid as an anti-rheumatic has been adopted by many physicians of our school. Page 106 he speaks of *ol. ricini* (castor oil), and remarks that in certain forms of chronic diarrhœa, where slight colic precedes a scanty thin stool, probably in consequence of inflammatory irritation of the mucous membrane from old indurated fœcal masses, the action of *oleum ricini* is excellent. In fact it may be said that it acts better in diarrhœa than in constipation. In the beginning of dysentery a fairly large dose acts well, especially where diarrhœa exists. Such homœopathic action is well understood, for in East India *ricinus* was highly esteemed as a remedy in cholera Asiatica.

Has the drug any influence on bacteria? This seems now-a-days the chief question in relation to the value of a drug, and Penzoldt looks to it even among plants, and whatever is not disinfecting and deodorizing has, in the year 1890, hardly any more a place in a *materia medica*. Thus, he considers cumarin a mild deodorizer, but thinks the *melilotus*, from which it is made, perfectly useless, and still this clover causes one of the most violent congestive headaches, relieved by bleeding, especially bright-red epistaxis. Much has been said of creosote in tuberculosis pulmonum, especially in putrid pulmonary processes; but its action is more than doubtful, and where it seemed to help, *guaicol*, more pleasant to take, may take its place. *Lignum*

guaico was formerly prescribed for syphilis, but can be dispensed with. Aqua pic is also thrown among old lumber, while *we* find *pix liquida* an excellent remedy, which I have verified over and over in consumption and bronchial catarrhs, where the purulent expectoration was offensive in odor and taste, and it is to be noted that while in tar the pain is referred to the left bronchus, in *guaicum* the pleuritic pain is felt at the apex. We of the new school are really old fogies; for we still prescribe *guaicum* for gout and rheumatism when the joints have become distorted by the concretions. Several marasmic children, suffering from *gastromalacia*, were saved by the internal use of *creosote* 30th. *Teste* considers it the grand remedy in the troubles of dentition. In neuralgia from decayed teeth it needs some study to differentiate it from *staphisagria*. Will *creosote* ever cure carcinoma? We doubt it, but we agree with *Penzoldt*, who considers its use in *phthisis* a great aid for nutrition and to keep up strength, and, after all, what is carcinoma but an expression of tuberculosis during involution.

*Acidum benzoicum* and *benzoate of soda* were old-fashioned expectorants—*requiescat in pace*. I wonder whether the erudite professor ever smelled or tasted the urine of patients who took it to raise the phlegm; for with us this strong smell of horse urine is one of the keynotes for its employment in gout, rheumatism, etc., from an excess of hippuric acid.

Of *camphora* *Penzoldt* says (p. 144) that it is a powerful stimulant for the depressed activity of the circulatory and respiratory organs, and it is too often only prescribed as an *ultimum refugium*; its expectorating action coincides with that of stimulation. Not a word said about the splendid indications for camphor in cholera, as *Rubini* has shown. While *camphora* prevents the collapse in the early stages of dry cholera, charcoal deserves more credit than of being a mere antacid, and in late stages of acute diseases, be they cholera, typhoid or any other malignant fever, it often sustains the waning powers of life till a favorable change can be produced. The worse the fainting spells, and the more the body becomes icy cold and bathed in cold sweat, the more camphor will be indicated.

*Terebinthina* and *terebene* are sometimes useful in putrid pulmonary processes, and internally as an antidote to poisoning by *Phosphorus*; and the same may be said of *Myrtol*. Some recommend them in chronic catarrhs of mucous membranes and in rheumatic neuralgia.

Our school also recommends *terebinthina* in infantile capillary bron-



chitis, when the clogging up of the bronchi renders the child drowsy, with scanty, dark colored (bloody) urination. In Bright's disease after scarlatina it saved for me several children, after the failure of apis, helleborus and other remedies, and the bloody urine was the keynote for its use. In fact, the renal symptoms of congestion are so characteristic that it may be prescribed with confidence from its urinary symptoms, and it is not difficult to differentiate terebinthina from cantharis, which lacks the sluggishness of the former.

"The glycosides offer a series of drugs, which are of importance in regulating the action of the heart and of the bowels.

*Digitalis* gives digitalin, digitalein and digitoxin, and it is astonishing that its methodical and energetic use is still too much neglected. Its general indication is the weak heart and its consequences. It is questionable whether arterial pressure is always increased by it, though arterial anæmia and venous stagnation usually go hand-in-hand with a small irregular pulse, but the pulse may also be regular and normally frequent or abnormally rare, and still *digitalis* may be indicated. The characteristic influence of the drug in the picture of disturbances of compensation in the activity of the heart consists in the retrogression of the œdema, of cyanosis, dyspnœa and other manifestations connected with it, and the increased diuresis depends on increased blood-pressure. It acts best in insufficiency of the cardiac muscle, setting in after over-exertion of the heart in idiopathic cardiac hypertrophies. It acts nearly as well in compensatory disturbances of secondary hypertrophies from valvular defects. One is not sure of success with it in muscular insufficiency in consequence of renal diseases, and it fails in fatty degeneration of the cardiac muscle. Extremely doubtful is the action of *digitalis* in the weak heart of acute diseases, especially of pneumonia. In nervous palpitations there are safer medicines than the slow-acting *digitalis*. Though the weak heart is the general indication for the foxglove, a tense pulse must not necessarily be a contraindication, and in anæmia it sometimes ameliorates in spite of a hard pulse. There cannot be a set dose, for it acts differently on different people, and one is not always sure of the purity of the drug, and the accumulative action of the drug is dreaded by many, as also the most distressing nausea and vomiting which it may produce."

So far Penzoldt! Weakness of the cardiac tissues is also with us one of the chief indications, and the slow pulse, or a feeble pulse becoming irregular or quick, but the large doses often prescribed are also often the cause of the dilatation of the heart. Baehr gives *digitalis* in diabetes mellitus, but its action here must be more than doubtful, just as we have better remedies in hepatic affections. In fact, *digitalis* was never employed on such a large scale by the fol-

lowers of Hahnemann as by the old school, and all consider it a good but tricky remedy. We need more provings of *strophanthus*. When Penzoldt says, "it may be prescribed instead of *digitalis* when a rapid action is desired," he fails to give us the indication. *Adonis* and *convallaria* have been partially proved, but find very little practical application, for we do so much better with our old tried friends, *spigelia*, *kalma*, *arsenicum*, *cimicifuga* and a host of others. We pass over his indications for purgatives, for we have very little use for them.

But I felt astonished when he gives *cannabis indica* the cold shoulder, as there are very few better hypnotics. According to him it hardly ever gave good results in mental alienations. Why? Because strict individualization of drug action is neglected, which, under Indian hemp means delusions as to distance and to time. The hashisch eater tells of its heaven and its hell. All over-excitement is followed by relaxation and this with the consequent mental torture; parietic tingling may trouble the sufferer. It is not often indicated, but when the specific delusions are present, no other drug can take its place.

The well-known ergotism ought to have shown the learned professor that midwifery is not any more the centre-point for the use of *secale*, for in its contractile power on the capillaries it has of late earned its greatest laurels; for its action on the vaso-motor nerves is undisputed. Thin, scrawny persons, whose blood has nearly lost its coagulating power, is to us the keynote, and we therefore find it useful in extreme cases of gastro-enteric affections when the patient looks as if there were no moisture left in the system, and though icy-cold cannot bear to be covered. He who saved one life by its use, well knows that *secale* has other indications besides midwifery. To differentiate it from *carbo vegetabilis* seems sometimes difficult, but the symptoms which caused the collapse differ. Let us close with the two heroes, so much abused by the old school, *china* and *quinine*, and *opium* and *morphine*. As an antifebrile drug quinine stands far behind antipyrine, but it will always remain the great specific for paroxysmal attacks. The typical malarial fever and *malaria larvata* yield to it when given in sufficient quantities and kept up after its appearance, but it is also the great preventative for persons travelling in malarious countries. It seems to be less effectual in intermittent, pernicious and in malarial fever. As a tonic cinchona bark is undeservedly praised and may often act injuriously on digestion; some persons even have a perfect idiosyncrasy to any preparation of china and its

alkaloids. Homœopathy certainly goes too often contrary to allopathic notions. To understand the full action of cinchona, the primary effect must be differentiated from the secondary ones according to the biological law of reaction. Hence we may have first, digestion stimulated, an increased appetite, followed by gastric disturbances, headache and dizziness. To us china is the great remedy for exhausting discharges of any kind, and it will give strength to the weakened heart with its insignificant, irregular pulse. As the remedy for marsh miasma we all acknowledge our fealty to china and quinine, and the more regular the paroxysm, the more will it be indicated. We must individually have the paroxysm in its different stages, or we will fail as the old school so often does when giving it for intermittents. Grauvogl's hydrogenoid constitution teaches us a valuable lesson for such cases will yield to the salts of sodium or aranea diadema, after being treated in vain with the usual antiperiodic remedies. Jousset and his French school taught us its value in rheumatism with its jerking and pressing pains and fear of being touched. To us china will always remain a tonic, but not an antipsoric, hence calcaria phosphorica will complement it in many cases.

Not a word about our *nux vomica* in his book; he prescribes strychnine in some cases of amblyopia and amaurosis, but is not very sanguine of its use in spinal paralytic affections, though some benefit may accrue after the inflammation had run its course, also in peripheric palsies and in vesical troubles. It can well be spared in disturbances of digestion, as there are better means for their removal. Great Cæsar! What would we do without our *nux vomica* and *pulsatilla* in gastro-enteric troubles, be they dyspepsia, constipation, or diarrhœa? Why we cannot get along without them when indicated. How many a catarrhal fever was strangled, as it were, by a suitable dose of *nux vomica*. We agree with Penzoldt that *nux* and strychnine find more indications during the active states of spinal affections than when paralysis comes as a final and too often incurable state.

Last, but not least, *opium* and *morphium*. Who would, who could, treat human sufferings, without opium, that God-given drug? So spoke Hufeland nearly a century ago, and the same blessing is called upon it by both schools, and still its abuse has done as much harm essentially as it has palliatively given relief. We feel pleased that Penzoldt here individualizes and wants morphine only used for such pains where it removes the cause which produces or keeps up the pain or after the failure of all other treatment.

Its chief indication is spasmodic contraction, as in colic, lead-colic, gastralgia from scars or spasmodic retention of calculi. 1. Euthanasia must and can be procured by morphine and in incurable diseases to relieve is already a great boon. 2. Insomnia, if caused by pain, but when in consequence of psychical unrest, the recently invented hypnotics are preferable. 3. Mental alienation, furor melancholia, mania, delirium tremens. 4. Convulsions and spasms. It does less in motory irritation than when the sensory nerves are affected and it may be of benefit in tetanus; lyssa. 5. Asthma nervosum, as it relaxes the bronchial spasms; in a purely expiratory dyspnoea it is injurious. 6. The same may be said in relation to cough. In hæmoptoe its quieting effect may be made use of. 7. Digestive disturbances; opium can only be indicated in diarrhoea after the removal of the fæcal masses about and really decomposing, and it may be therefore advisable to give a laxative before resorting to opium. In constipation and colic the stagnating fæces are often hurried onward after failure of purgatives; in ileus it may also be indicated. In perforation and in hæmorrhage of the intestines opium per os and per rectum is our only safe guide. 8. Opium, morphine and codeine are recommended in both forms of diabetes, though often transitory benefits only result therefrom. Apomorphine is a most suitable emetic, especially subcutaneously, and in very small doses it is an excellent expectorant.

Some may feel astonished that so many of these indications also hold good under homœopathic principles, for we may prescribe it for that extreme susceptibility to pain which threatens convulsions or at least twitching and jerking of the limbs. To us the secondary effect of distension of bloodvessels, the full and slow pulse, the purple face, the stertor of breathing, the blowing puffing of the cheeks, the coma and the palsy, are hints, of which the old school failed to make any use, and no matter what the name of the disease may be in infancy or in senility when we meet this complex of symptoms opium is indicated. In bloated drunkards and their ailments, with their disordered vital force, it is sometimes the needed tonic to tide them over the danger spot. We also may give it for colicky pains, but only when there is great bloatedness, and the passage of flatus gives no relief, just as we may use it for the relief of strangulated hernia or intestines, though nux and plumbum may be more closely indicated. The mental symptoms of opium are for us mighty useful hints.

How can it be possible to work for a union of all schools as long as the dominating and domineering school refuses to be taught the principles which underlie the practical application of the law of similarity. It is most astonishing that, though their learned men accept

individualization in relation to patient and disease, though they make physiological experiments on dumb animals and try to reach conclusions from autopsies, still to individualize the drug so that it may be differentiated from its compeers, still remains a prime desideratum. When Penzoldt (page 198) puts belladonna, hyoscyamus and stramonium under one heading, all we can do is to pity them that they do not try to do better. They must learn from us; they must be forced to listen to the rules and regulations by which our *materia medica* was worked out; they must compare their provings on animals with our provings on living rational beings; they must listen to the appeals of their progressive teachers; their students must be instructed in the application of substitutive medicine, and when this becomes an accomplished fact then we might consider it worthy to drop our sectarianism. Till then I say with friend Helmuth: I am proud to be a sectarian.

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#### CLINICAL NOTES ON THE USE OF ALSTONIA CONSTRICTA.

BY W. G. DIETZ, M.D., HAZLETON, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

CASE I.—Miss M., æt. 23, came under my care four years ago, with the following history: Has always been a pale delicate girl, subject to frequent fainting spells. Commenced to menstruate at the age of 14, without much trouble, and has continued to do so regularly ever since. Had frequent attacks of suddenly losing her voice. Had been under allopathic treatment for long periods.

*Status quo at the time she came under my notice.*—Pale, emaciated; complained of great debility. Weak feeling in whole abdomen accompanied by a dragging sensation as though everything would escape through the vulva; nausea in the mornings on getting up; has to lie down again to prevent vomiting; frequent fainting spells, especially after her menses. Very despondent; thinks she will die. The pale face flushes up from the least excitement (has taken iron *ad nauseam*). Appetite always poor; the food seemed to remain undigested in the stomach for a long time. Tongue coated white, with very red edges. Frequent attacks of cramps in the stomach after midnight. Diarrhœa, with stool of undigested food, immediately after eating; has to leave the table before finishing her meal (ferr.). Urine normal, sp. gr. 1.018, acid reaction, and containing neither albumin nor sugar. Frequent attacks of palpitation.

I commenced the treatment with *pulsatilla*, and gave successively

sepia, lilium tig., aletris, sulphur, aloe, and natrum mur., giving each remedy a fair trial, with varying success, relieving symptoms for a time, to reappear again with renewed force; so that, at the end of a year, my patient was not much, if any, better than when she first came under treatment. I now put her on alstonia const. 1x, a dose every three hours. In a short time improvement manifested itself, and continued uninterruptedly, so that at the end of another year she had changed from the pale sickly girl to a stout healthy woman. Only occasionally does she feel a return of the dragging sensations in her abdomen, but a few doses of her remedy always relieve her.

CASE II.—Miss S., æt. 22, about four years ago, while nursing a near relative during a prolonged illness, commenced to be troubled with a yellowish-brown leucorrhœa, very weakening, and soon followed by a dragging and bearing-down sensation in the uterine region, making walking quite painful, and at times almost impossible. Great deal of lumbar backache. Shooting and throbbing pains, at other times an aching in right ovarian region, which is painful on pressure. Menses dirty-brown, accompanied by cramping pains in the uterus, and always preceded by diarrhœa. Has been treated by a noted gynæcologist in one of our eastern cities, who made local applications of Churchhill's tincture of iodine, and other similar measures, without, however, producing any lasting beneficial results to the patient, who came under my care about a year ago, with the above symptoms still persisting, and, in addition, complaining of great debility, with nausea in the mornings on awakening. She presented a florid appearance, fairly well nourished, and has always enjoyed an excellent appetite. Physical examination revealed a greatly anteverted uterus, cervix eroded, with the objective symptoms of endocervicitis. Tenderness in the right iliac fossa. Aletris, calc. phos., bell., kreos., and nitr. ac., all seemed to benefit the case, without, however, bringing about a radical change for the better. About three months ago, I put her on alstonia const., which she has taken steadily ever since, with the following result: The morning nausea left her very soon; the dragging sensation and bearing-down in hypogastrium, as well as the leucorrhœa, have well nigh ceased entirely. In fact, with the exception of the pain in the right ovarian region, which remains the same, she considers herself nearly well. The diarrhœa, also, did not make its appearance before the last menses. The uterus, although movable, still remains in its anteverted position.

CASE III.—Mrs. G., æt. 28, mother of three children. About a year ago, during prolonged lactation, commenced to have sore, aching pains about the heart, with great soreness of the gastric region, which is sensitive to pressure. She came under my observation about two months ago, with the following symptoms: Constant dis-

truss in region of stomach, a feeling as though something was lying there which should be removed, worse a few hours after meals. Occasionally, an empty gone feeling in pit of stomach. Sharp, shooting pains, extending from the left side of stomach through to the back. At the moment she falls asleep, she starts up suddenly, becomes wide awake, with violent palpitation of the heart and throbbing in bloodvessels, accompanied by a numb sensation of the tongue. Pulse 84, soft, compressible. Patient looks thin and pale, and has been overworked with family cares. After taking alstonia for six weeks she informs me that she is entirely relieved of all her symptoms.

CASE IV.—Mrs. W., æt. 56, ill-nourished, scrawny-looking; complains for some time of great weakness, especially mornings. Empty, gone feeling in stomach, < towards evening. A sore, swollen feeling in right ovarian region; dragging-down sensation in hypogastrium. Has taken lots of allopathic mixtures. Alstonia cured promptly.

CASE V.—Miss K., æt. 25, dark brunette, very active. Has complained, off and on, for years, of a dragging sensation in the uterine region. For the last six weeks, frequent attacks of nausea, with empty gone feeling in pit of stomach, generally brought on when exerting herself. Alstonia relieved the latter symptom at once, without a return since.

CASE VI.—Mrs. B. æt. 32, a hardworking woman, of rather small size, though fairly well nourished, and the mother of four children, youngest three years old; has suffered from simple prolapsus uteri for years; otherwise, enjoys good health, except occasional attacks of intercostal neuralgia; bearing down, with weak, empty, gone sensation in pit of stomach. Aletris relieved at first but symptoms returned—it failed to benefit the case. Gave alstonia, which speedily relieved her, and there has not been a return since, now nearly a year.

I could cite *more* cases, but the above will suffice to call attention to a remedy which will prove useful in a class of disorders, especially in those peculiar to women, which frequently prove quite rebellious, even under the most carefully-conducted treatment.

In the absence of extended and reliable provings, and by the light of my own experience with this remedy, I consider the following symptoms as characteristic for its employment:

1. Great debility, with loss of appetite and weak digestion. Tongue generally coated a dirty white, especially toward the base, although it may be clean. Debility appears to be the key-note for the employment of this remedy, if dependent on a lack of digestive power of the stomach, or else, assimilative power of the system at large. In debility of a purely nervous type, it has failed entirely; nor has it

proved of marked benefit in the prolonged depression of the system following severe cases of la grippe.

2. Nausea, < mornings before breakfast, or at irregular times, especially when depending on reflex irritation due to disturbances of the pelvic organs. I have not, as yet, given it a trial in the nausea and vomiting of pregnancy, but shall do so at the first opportunity.

3. An empty, gone feeling in the stomach, or else in the whole abdomen, coming at irregular times, and generally associated with bearing and dragging down sensations in the hypogastrium.

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### A CASE OF REMITTENT FEVER, WITH HÆMORRHAGIC COMPLICATIONS.

BY G. MAXWELL CHRISTINE, A.M., M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania.)

THE two fevers, remittent and typhoid, having in their gross or superficial aspects some features in common, it has been suggested that I make a case which came under my notice and which aptly illustrates this statement, the subject of a paper for this Society. I am furthermore prompted to do so, because, upon the surface it has enough features about it to warrant, seemingly, the diagnosis of typhoid fever, and not that which was made—remittent fever with hæmorrhagic complications.

The differential diagnosis of these two diseases is an easy one in typical cases; but disease, of whatever character, will not always assume the typical character, and hours, and days, and sometimes years, will be spent in anxious watching for such a grouping of disease-manifestations as will permit us to know their source. Not every disease-manifestation is open to the senses of the observer, but it often remains hidden, for, as year after year goes by and the various helps to diagnosis are given to the physician for his use, we find these hidden symptoms coming forth to be matters of knowledge. Ignorance, as applied to medicine, is a comparative term, for it will never be in the grasp of man to know all concerning disease, and we censure, and will be censured, for errors in diagnosis according to the light given us by which to be guided. Our knowledge concerning both remittent and typhoid fevers is, no doubt, environed within narrow confines, particularly appearing to be so when we conceive of the possibilities of future investigators. Whilst within the past decade, in



particular, a certain and considerable progress has been made respecting these fevers, it is likewise true that they have not been rid of that mystery which has ever puzzled, and for long time will continue to puzzle the physician, and therefore, to a proportionate extent, baffle his treatment.

The question naturally arises in this connection: Will a period ever arrive when, by some means certainly not now definitely and absolutely known, disease will be identified at the hour or day of its inception, or even at any time during its course? If such a fortunate period ever does arrive, it will be when the disease-cause is possible of identification. At present, we must be content with little more than the accumulation of symptoms, and in their grouping and analysis, with the approximate determination of their cause. Bacteriology has, undoubtedly, taken the advance step in this disease-individualization. Even now, bacteriologists claim to be able to arrive at a true knowledge of the nature of disease in their asserted discovery of bacteria special to many diseases, and microscopists present strong claims for having done much toward the identity of disease. If they have succeeded in so doing, even in one disease, they have materially added to the power of the physician over disease.

A. B. C., a lad of thirteen summers, lived, in the year 1888, in a house which had been condemned by the Board of Health on account of sanitary defects. Together with a companion, my patient played, as boys will do, in the yard of the house, digging the soil, though it gave off with every shovelful, the odors of the contained fecal discharges which a long while before had escaped from the privy-well into the earth. While at Lake George, in 1888, he developed malarial symptoms, which lasted indefinitely throughout the summer and fall months into the winter. In the middle of December, he he was in bed with an attack of follicular tonsillitis, which lasted several days. After this, he was comparatively well until January 17th, when he went to bed with a fever, for which, for a few days, he was given home remedies. On the 19th I was summoned. There was a history of a chill at noon, followed by a sweat, with complete intermission in the mornings, upon which basis I made a diagnosis of intermittent fever. For six days after I had been called, the intermissions continued, when they gave way to remissions. From this time forward the disease continued for six weeks.

Following, is the chart of the temperature and bowels. No record of the pulse is given in the chart, that being below 100, even at the time of the highest fever, except at the period of hæmorrhage.

As we study the chart, no difficulty will be experienced in comprehending the intermittent character of the fever up to the 23d, the



with more or less variation until the 30th, when there was a decline in the fever both morning and evening. The temperature went down to 98° on the morning of the 31st. But, thereafter, the fever continued to the 4th of the next month (February), when it again began to show an inclination to abate; but on the 8th it again began to rise in the P.M., continuing at about 100° in the A.M. until the 12th, when it began steadily to rise both morning and afternoon. This rise of temperature continued until the 15th.

This gives the fever curve for four weeks of the lad's sickness. I will pause here to relate the other symptoms from the period of first remission.

Had the thermometer not been used during this period, from January 25th to February 12th or 13th, the detection of fever would have been impossible. The skin was natural and generally moist. The tongue was moist and slightly coated, and of a bluish-gray color. The eye was bright; the cheeks rarely flushed; the pulse ranging at 100, of good quality and volume. There was no delirium, sleep was good, and the lad usually awakened in the morning refreshed. The appetite was good, but it was kept under bounds, the diet being a "typhoid regimen." There were no tympanites, no right iliac fossa tenderness, and no tenderness at any part of the abdomen except on the 28th, when slight tenderness existed in the left abdomen over the colon. On the 27th, the lad vomited curdled milk; the urine had a specific gravity, at this date, of 1022; no albumin. On the 29th, the patient was remarkably bright, the pulse was 88, and the prospects for a speedy resolution were good. On the 30th, the bowels moved by injection; feces were dark in color, but of normal consistency, and had no offensive "typhoid odor." The pulse was 80 on February 2d; the bowels were again moved by injection. On the 5th, the patient complained more than usual of chilliness. Bowels moved again on the 6th; feces normal in odor, dark in color and normal in consistency. Pulse 88 on the 11th; bowels moved this day by injection. On the 12th, vomited about half-ounce of bile, and vomited again in two hours thereafter. I had a consultation on this day with Dr. A. R. Thomas. On the 14th, vomited half-cup of bile; no albumin in the urine; pulse 100. On the 15th, the urine was dark and slightly albuminous, and had shreds of blood in it; there was cough, with slimy and slightly bloody expectoration, and there was a profuse sweat; the tongue was slightly dry and brown (the first departure from the moist blue-gray character it had ever before assumed).

The diagnosis of the disease up to January 25th was easily made of intermittent fever, but on the cessation of intermissions there had to be a differentiation established between typhoid and remittent fevers. Careful and laborious examination was made for the purpose of establishing an identity of the disease with typhoid fever, but the tests failed in every respect. In nearly every particular,

however, the diagnosis of remittent fever was supported. In this diagnosis Dr. Thomas agreed. In support of this diagnosis was the following: Non-conformity of the fever-curve with the typical typhoid fever-curve, or with any undoubted typhoid fever-curve; the beginning intermittent, and subsequent remittent, character of the fever; the absence of delirium and all other nervous phenomena; no "dull, heavy, throbbing, persistent frontal headache; twitching of muscles; tickling of throat; ringing in ears; deafness; mind stupid;" no bleeding of the nose; no abnormality in the quality of the pulse; no uniformity in the fever manifestations; no sordes; no trembling of the tongue nor coating on it characteristic of typhoid; urine non-albuminous, heavy, as usual in malarial conditions; no diarrhoea, but constipation, the stools normal in character, at times bilious; no tympanites, but abdomen depressed; gastric disturbance, and the little one-day-existing abdominal distress referable to the colon; no splenic involvement; vomiting of bile; no rose-colored spots nor sudamina.

Yet, beginning with the 12th, the morning and evening fever steadily arose, and there was sufficient justification in the inquiry as to whether the case was not typhoid, masked or modified. But on the 16th and 17th, improvement became marked in some respects, and the diagnosis was still made of remittent fever. On the first of these dates there was vomiting of bile, with gastric and hepatic uneasiness. In the evening the nurse reported the pulse to have weakened for awhile and the patient to have been restless, an unusual symptom. The next day, the 17th, Dr. Thomas and I found the pulse good in volume but frequent, difficulty in voiding urine, and vomiting of mucus and bile. In other respects, the lad appeared to do well, though the fever stood, at 12 M., at  $102\frac{3}{4}^{\circ}$ . The abdomen was still depressed, and no uneasiness was manifested in that part.

At 2 o'clock of the same day, however, a large hæmorrhage of the bowel took place without warning, another at 4.20, and others at 4.38, 6, 7, 7.30, 8, 9, 10, 11 (P.M.), 1.45, 2 (A.M.), and three others at hours not recorded, making a total of fifteen. Collapse became profound, and the utmost and prolonged efforts at resuscitation were necessary from the time of the first hæmorrhage to several hours after the last to save the patient's life. The lad rallied, however, and on the 6th of March had the last symptom of fever.

These intestinal hæmorrhages had been inaugurated by slight evidences of blood in the urine for several days, and by streaks of blood

in the expectoration. It is in these hæmorrhages that the case is so interesting, furnishing one of those cases which, while purely malarial in character, have one symptom commonly associated with typhoid fever and apt to put doubt upon the diagnosis of malaria. The hæmorrhages in this case were doubtless due, not to glandular changes, but to mucous congestion, a common symptom in malarial fevers of prolonged issue, but one not frequently of the magnitude and fortunate result described above.

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### A CASE OF MONSTROSITY.

BY C. A. YOCUM, M.D., POTTSTOWN, PA.

(Being an Abstract of a Paper read before the Homœopathic Medical Society of the State of Pennsylvania.)

ON August 20, 1889, I was engaged to attend Mrs. — in her approaching confinement. Nothing unusual was noted at the time, except an abnormal distension of the abdomen. On September 3d she was taken in labor. The presentation was by the face. Successful efforts were made to convert this into a vertex presentation, but on the return of severe labor pains the head resumed its former presentation. Continued labor pains impacted the head, and made the use of the forceps necessary. Several futile attempts to deliver with the aid of these instruments were made. I then sent for a consultant. No homœopathic physician being obtainable, an allopath was called in, and he, after making an examination, essayed to put on the forceps. In attempting to introduce the female blade he met with such great resistance that he used great force and produced considerable hæmorrhage. His manipulations were such as to make me very much dissatisfied with his assistance, so I determined to seek other counsel. During my absence he continued his efforts with the forceps, and when I and my new consultant arrived, we found the woman in a dying condition. We now performed version, and after great difficulty succeeded in bringing down both feet and delivering as far as the hips. As a last resort, the legs of the child were tied together with a towel, and by continued and persistent manipulation and traction we finally succeeded in delivering the child. We then

learned, for the first time, the cause of the difficult labor,—a deformity of the foetus. The force used in delivery had broken the occipital bone. The mother died one hour after delivery, notwithstanding persistent efforts at stimulation.



I will not attempt to describe the monstrosity in detail. The accompanying photograph of it will give a better idea than I could in words. Sufficient it is to say that the deformity consisted of an absence of the cervical vertebræ, the occipital bone articulating with the first dorsal vertebra, being firmly fixed to it at an angle of about 60°.

I have often questioned whether proper treatment at the right time would have saved the mother; whether it would have been possible, under the circumstances, to have saved her life. The deformity was certainly of a character well calculated to mislead the obstetrician. Had it been recognized in the beginning, we might have performed craniotomy.

Many who have examined the photograph remark that the child resembles a lion in appearance. It may be of interest to state that the mother was frightened by a lion during the fifth month of her pregnancy.

## FERRUM PICRICUM IN DEAFNESS.

BY ROBERT T. COOPER, M. D., LONDON, ENGLAND.

(Physician, Diseases of Ear, London Homoeopathic Hospital.)

MISS F. A. S., a District Visitor, aged 32, living in Chelsea, was sent to me on May 2d, 1890, with deafness. Her history ran thus :

As a child had deafness, which followed upon diphtheria, but was cured by the late Dr. William Harvey, and within the last five years has again been getting deaf, but very much worse the last eighteen months. Was born in India, and has suffered from her liver a good deal. Deafness began, she supposes, with a cold.

*Symptoms.*—Not much tinnitus ; headache, when tired, across the forehead and in the eyeballs ; tonsils and back of throat feel uncomfortable, but this I attributed to a small superficial chronic abscess on the upper surface of the right tonsil, and which burst while under examination.

Deafness is worst in damp weather, and also when easterly winds prevail. Hearing for watch, R., 2½ inches ; L. (the worst), barely 1 inch. What was particularly striking, was the patient's jaundiced—chronically jaundiced—appearance, and this, together with symptoms of weak digestion, confined bowels, and bad appetite, led me, without further inquiry to give *ferrum picricum* 3d dec., seven drops to ½ oz. of water, and five drops of this thrice daily. In a fortnight she returned to say she had been very much better the first week, and then had a good deal of worry, which put her back, and now, her throat feels uncomfortable, but, even so, her hearing is greatly improved, and she feels generally much stronger and better. Hearing distance, R., 30 inches ; L., 9 inches. I advised a continuance of the ferr. picr. 3x, one dose every night at bed-time, and to discontinue treatment after ten or twelve days of this. Within the last fortnight (September 26th, 1890) I heard from her friends that she was perfectly well.

The indication here was the decided hepatic complication, and the overpowering effect of fatigue ; and when, along with this liver-sluggishness, we find a circulation that is not broken down by senile degeneration, we may safely look for a speedy cure of the deafness by the *ferrum picricum*.

Among other symptoms that call for *ferr. picricum*, is a great sense of weight and oppression about the region of the heart, due, in some cases, to mitral valve disease, and an oppressed feeling low down in the right side, as if from myalgia and pleurodynia combined, but diffused, and not merely concentrated in the submammary regions as are purely ovarian pains.

## EDITORIAL.

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### MEDICAL LEGISLATION IN PENNSYLVANIA AND HOMŒOPATHY.

IN the *Medical and Surgical Reporter*, for October 18th, appears an editorial bearing the title "Medical Examiners and the Homœopaths." While the writer thereof is evidently actuated with fair-minded motives, we feel obliged to differ from him in his conclusions. He states in most positive terms his friendliness to a medical law which shall place the licensing of physicians in the hands of a board of medical examiners, the selection of such board to be made by the governor of the State without regard to school of practice. In other words, he is willing that the governor shall, untrammelled by restrictions in the law, appoint all homœopaths, all allopaths or all eclectics, as his feelings may prompt him to do; or he may divide the appointments equally or unequally among the three medical sects. This position sounds very nice on paper, but practically it will not work, because if the governor should perchance (and it will only be a chance) give the majority of appointments to any other school, or even schools, than the allopathic, the law will at once become highly objectionable to the self-styled "regular" members of the latter sect.

Our contemporary refers to the fact that many members of his school dread the enactment of a medical examiners' bill because it enforces a recognition of the rights of the homœopathic school. This dread does exist, and not only that, it is wide-spread. We but recently heard a prominent allopathic surgeon, well known for his bigoted conduct towards homœopaths, raise objections to such a law because the self-styled regular members of the board would be compelled to affix their signatures to the licenses of homœopathic physicians, such action on their part being in direct opposition to the teachings of the code of ethics of the American Medical Association. While he was making this speech he gave strong evidence by his manner that he would not, unless actually compelled to do so, sign such a license.

The editor of the *Reporter* then directs attention to the fact, which also is strictly true, that the homœopaths stand in fear of an association with the allopathic examiners on the board; that is to say, they dread unfair treatment of homœopathic applicants by the allopathic members of the board. Let us ask if past events do not jus-



tify us in entertaining just such fears? At the same meeting at which the eminent surgeon made the speech above referred to, another practitioner actually proclaimed that homœopaths were not deserving of the slightest protection at the hands of the law; that if he had his way he would have every homœopathic physician in the land in jail inside of twenty-four hours. We even believe that he would have had every believer in homœopathy in jail also if prison accommodations could have been obtained. Another physician, at another meeting, said that "every homœopath should be hanged by the neck until he was dead three times." But Dr. Dulles will at once say that these men are exceptions to the more intelligent members of his profession. We say that they are not exceptions; they are only bolder in the expression of their opinions. We call to mind a prominent specialist (allopathic) in the city of Philadelphia who refuses to meet homœopaths in consultation. Yet that man will examine the patient of a homœopathic physician providing the homœopath is not present, and give an opinion in writing in the form of a letter to the head of the family. In other words, that man is fully aware of the bigotry of the code which forbids his association with homœopaths in consultation; and yet he stands so in fear of the discipline of his profession that he allows himself to bow down to bigotry and prejudice. Let such a man be appointed a member of a mixed board of medical examiners, and although it may be his intention to act fairly, yet when he has once been appointed, the pressure brought to bear upon him by the mass of his profession will lead to unfair treatment of homœopaths on his part. In other words, he does not own himself; he is the slave of others.

Dr. Dulles says that the measures proposed at the recent meeting of the Homœopathic State Society of Pennsylvania are thoroughly impracticable; that what was proposed has never been carried out and never will be. The Committee on Medical Legislation of the Pennsylvania Homœopathic Society recommended that a law be enacted that would fix the standard of preliminary education before admission to medical colleges. Is that provision impracticable, and is it not just? No one will object to it except the faculties of such colleges as have been accepting as students men who were unfitted to begin the study of medicine. Such a law will lessen their incomes, and self-interest will prompt them to object. Another provision made by the State Society was that the medical colleges should be under State supervision. Is there anything impracticable in that?

Our esteemed contemporary is desirous that we, as a school, shall give a support to a law providing for a board of medical examiners. This we can never do while the act creating such board provides for the power of licensing homœopathic physicians being placed in the hands of allopathists. If, on the other hand, the legislative committees of the various allopathic societies agree to a bill which shall give to homœopaths the exclusive privilege of licensing applicants of their own school, then will they receive our support in their efforts at passing a medical examiners' bill.

We must, however, express as our belief that such a law will not strike at the root of the evil. Men may pass most excellent examinations before college faculties and medical examining boards, and yet in after life exhibit but little ability as physicians. Worse than that; having obtained a diploma or a license, as the case may be, they become mere money makers, never studying, never increasing their store of knowledge. What law can reach such men but one that shall provide for a selection of men eligible to medical studentship. It is really men of that class who constitute the ignoramuses of the profession to-day.

In closing, let us suggest that if the allopathic sect really wishes to elevate the professional standard, it should follow the example of the American Institute of Homœopathy. Let the American Medical Association withdraw its indorsement from all colleges that do not uphold a minimum attendance upon lectures of three years, and that do not provide for a certain curriculum. Furthermore, said Association should make ineligible to membership, both in it and its dependent county and State societies, all physicians graduated from colleges that do not uphold the Association's standard.

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#### HOMŒOPATHY IN THE SOUTH.

HOMŒOPATHY has not flourished in the South as it has in the North, in the East and in the West, chiefly for the reason that other fields have been more inviting and because that, up to the present decade, the advent of the stranger within her sunny borders was not a matter of rejoicing on the part of her inhabitants. Progress has since waved her wand over this attractive section of our country, and the South has awakened; she has shaken off the lethargy that enthralled her, and she now stands a giant astonished, and astonish-

ing the world, at the vastness of her resources. The hum of industry breaks the deathly stillness of her valleys and mountain slopes. The welcomed stranger pours into her domain from every State and country, and we have now a new South—active, energetic and progressive, with a future that is dazzling the world. Energy, industry and homœopathy go hand in hand. Our pioneers and missionaries are anxious to become of these people and to settle in their midst.

But they are amazed by being confronted with State *class legislation*. that is infamously proscriptive. Alabama would repudiate with indignation any attempt to throttle religious liberty, and yet she has permitted her allopathic physicians to betray her into destroying *medical* liberty. The people coming into this State may bring their ministers and their lawyers, but they are denied the choice of their physicians. Only the arrogant, self-styled “regular” doctor is welcomed to Alabama—so says her statute book. What a burning disgrace this law is to the fair fame of the brightest star in the Southern constellation! What are we homœopaths to do to awaken Alabama to a sense of her injustice? There are at present but twelve or fifteen of our number in the State. These men are making an heroic effort to regain and maintain their just rights and liberty. They are now calling for help. They need assistance. They are fighting for life against overwhelming odds. Their Southern colleagues, who are menaced by the same condition that now confronts the homœopaths of Alabama, are responding nobly to the appeal of the distressed. But they are few in number, they are weak in their own States, and their resources are not equal to the demand, no matter how willingly or how generously they respond. What then can the North, the East and the West do to inspire zeal, to impart new strength and courage to our southern associates in their battle for medical liberty and toleration? On the 12th, 13th and 14th of November, 1890, the Seventh Annual Session of the Southern Homœopathic Medical Association will meet at Birmingham, Ala., for the purpose of taking counsel together, and to map out plans for future action. The Association, through its journal, the *Southern Journal of Homœopathy*, has issued an earnest appeal for the attendance and the support of their northern, eastern and western colleagues who are interested in the growth and development of homœopathy in the South. You can attend this meeting; in fact, as a homœopathist, you are duty-bound to attend; and many of us can go if we will give ear to duty’s call. Let us see to it that the pioneer does not cry in vain to us for help. If the time is too short to prepare a paper on a medical or legis-

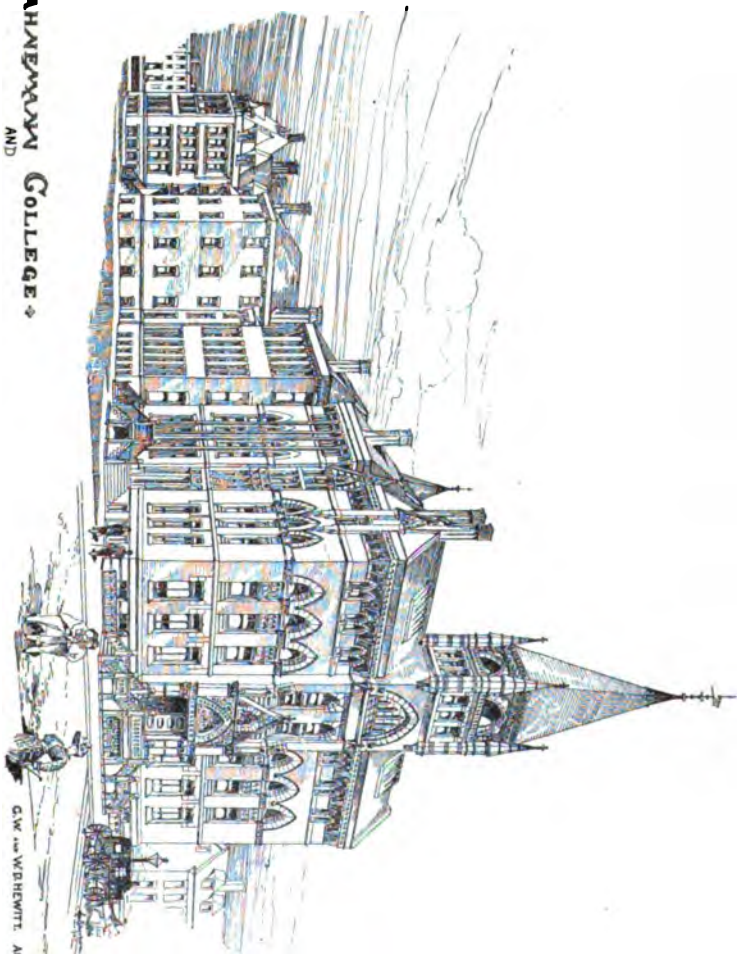
lative topic, go without one. The sympathy and support of your presence alone will be of incalculable value. The inspiration of numbers will enthuse our southern conferrees; and the effect of a large and determined meeting upon the citizens of the State of Alabama will be to catch the tide of public opinion at its flood and lead on to victory,—to the establishment of a *liberal* medical law in Alabama.

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#### THE HAHNEMANN HOSPITAL, PHILADELPHIA.

TUESDAY, October 21, 1890, was a red-letter day in the Homœopathic history of Philadelphia. It was a day of celebration, the occasion being the opening of the New Hahnemann Hospital, situated on Fifteenth Street north of Race. This structure completes a magnificent group of buildings (see frontispiece) occupying the full length of an old Philadelphia square, or what is equivalent to two New York blocks. The hospital, practically three buildings in one, together with the structure which is devoted entirely to the treatment of out-patients, and the college building on Broad Street above Race, make up what is conceded to be the handsomest and most completely appointed institution of its kind in America. The capacity of the hospital is one hundred and fifty beds, which in an emergency can be doubled, as in following the teachings and precepts of sanitation and hygiene twice the ordinary floor space has been allowed to each bed. It was eminently proper that celebrated jurists and renowned divines should join with the physicians in the dedicatory exercises, and help emphasize the lesson of the gala day—that a handful of determined spirits, energetic and persistent, with an effective organization, can accomplish mighty results and reap luxuriant prosperity. For thirty-seven years the Hahnemann Medical College and Hospital occupied the old church property and factory building on Filbert and Cuthbert Streets; these served their purpose well until the Centennial year, with its inspiration for greater things, disturbed the even tenor of her way. For eight years the Faculty, as a unit, and a number of the trustees endeavored to find ways and means to improve their condition, with a uniform lack of success. In 1883 the college authorities suddenly realized that future success demanded new and commodious accommodations and that the one way to secure them was to go to work and build at once. Despairing of harmon-

♦ HAHNEMANN COLLEGE ♦  
AND  
HOSPITAL



G. W. and W. B. HENRY, ARCHT.  
PHILADELPHIA.





ADDENDUM TO EDITORIAL ON MEDICAL LEGISLATION IN PENNSYLVANIA  
AND HOMŒOPATHY.

THE *Medical and Surgical Reporter*, for October 18th, 1890, and the *Journal of the American Medical Association*, for November 1st, 1890, quote Dr. Joseph Price as saying, when discussing the use of the uterine sound at a recent meeting of the Philadelphia County Allopathic Medical Society, that it was "a common method of determining the existence of pregnancy, particularly among homœopaths!"

What claims can such an individual have for the appellation of gentleman who will go out of his way to use such an unnecessary and unwarranted piece of mud slinging; what should be thought of a so-called scientific society that will be entertained by such an outrageous lie; or journals that will respect their school so little as to give circulation to such a piece of blackguardism. If Dr. Price did say this, don't you respect your society and your school enough to suppress it in the *abstract* of a discussion? It certainly savors of approval and enjoyment on the part of the *Reporter* and the *Journal*. And yet you talk of examining boards composed of men, presumably of this type, who shall impartially examine graduates of homœopathic colleges!



izing the differences of Trustees, the Faculty picked up its valuable museum, tucked its charter under its arm and with its treasury, without one dollar of treasure, shook the dust of nearly half a century from its feet and started in search of a new home. It took true American grit, without one dollar in the treasury, to contract for a lot of ground costing \$104,000, and requiring an immediate payment of \$1000, and three weeks later, \$20,000 in cash, to get possession, yet the results have justified the faith and courage of these men. In the first year \$23,000 was collected; this was a good starter; it showed what could be done, and it has been constantly improved upon; during the past ten months of the present, or eighth year, over \$115,000 have been gathered together. This speaks for itself, especially when it is remembered that there has been no one great contribution, but that it has been made up of innumerable comparatively small donations. In the past eight years the friends of the Hahnemann Medical College and Hospital have collected the vast sum of \$345,834, and with this money a great college and hospital have been erected that reflects both honor and credit upon our profession.

The appointments of this now completed institution, even in the most minute detail, show beyond any reasonable doubt, the greatest care, the most discerning judgment and an excellence of good taste; and whereas great credit is due to all who have worked for this end, the honors rightly belong to Dean Thomas and Registrar James; what these men have sacrificed to bring this immense undertaking to the finished success it stands to-day, they alone know, and they alone can appreciate.

The furnishing of the buildings was left entirely to the Board of Lady Managers. The manner in which this important part of the work has been done tells the story that every thing has received their personal supervision and that nothing has been left to chance; the visitor is at once impressed that here at last is a hospital furnished in the simple elegance and with perfect taste that characterizes the home of refinement.

It will be interesting to the profession to know that thirty handsomely furnished rooms, in a building entirely separated from the general wards, have been provided for private patients. It is the intention that these rooms shall be under the complete control of physicians who may desire to treat their private cases at the hospital.

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

**STRYCHNIA AS AN ANTISPASMODIC.**—Prof. Moritz Benedict, of Vienna, treated a case of chorea major in a young girl for a long time without getting any beneficial result, but finally called to mind Trousseau's recommendation of strychnia subnitrate (0.1 for 30 pills, 3 to 5 being taken daily). The drug was given and the patient cured. This action of the drug seemed to Benedict paradoxical, though he had taught for a long time that paralysis and spasms are not antitheses, and that irritation of the same central or peripheral systems causes spasms, whose destruction gives rise to paralysis, and that Romberg made a mistake in calling such affections (spasmodic (hyperkineses). Spasms are rather symptoms of diseased central or peripheral systems which, in a strict sense, have nothing to do with voluntary motion. In most cases of spasmodic affections we do not have to deal with states of irritation in these central or peripheral systems, but far more with lack of development, atrophy or destructive processes in these systems. It need not astonish anybody, then, that a drug which produces spasms in the healthy also cures spasms when caused by a diminution of the nutrition of these systems.

Strychnia also acts well in a nervous affection which has hitherto refused to yield to other remedies, namely, paralysis agitans.—*Allgem. Med. Centr. Zeitung*, 67, 1890.

**ATROPINE AS AN ANTIDOTE TO CYANIDE OF POTASSIUM POISONING.**—A young man took a considerable quantity of cyanide of potassium with suicidal intent. To make assurance doubly sure, he followed it with a large dose of atropine. He made a rapid recovery, and was well the following day, though nothing was done for him to counteract the effects of the two poisons. Atropine should be borne in mind as a possible antidote to cyanide of potassium.—*Deutsch. Med. Wochenschr.*, 56, 1890.

**PARALYSIS AGITANS.**—In his consideration of this subject, Bergherini, of Padua, says that heredity plays an important part in the etiology of the affection. In a family of nine, between the ages of 60 and 84 years, seven suffered from paralysis agitans, and three of their descendants had the same disease. Some cases apparently originate spontaneously as a result of slowly progressive changes in the nervous centres. Severe mental shocks, traumatism and rheumatism may also be mentioned as causes. A characteristic of the tremor is its irregularity. Sometimes it is so severe that the patient cannot take food, while at other times the patient can, by a strong exercise of the will-power, restrain it for a time. In the latter case, the tremor becomes much stronger after its attempted voluntary control is abandoned. Such patients can write fairly well, but an explosion follows the act. Speaking becomes tiresome; the pulse and respiration remain normal; the temperature is slightly increased; sensibility is normal; the sensations of heat, of which so many complain, may be caused by modifications of the capillary circulation. The tendon reflexes and electro-muscular irritability are reduced. The urine shows a diminution in the sulphates and phosphates, and an increase in the quantity of urea eliminated. Post-mortem, Bergherini found sclerosis of the pons, medulla oblongata and spinal cord. The pathological changes were found in both gray and white matter, though especially in the former. In the white substance of the cord, the anterior and lateral motor tracts were especially affected. The spinal roots, especially the anterior, the peripheral nerves, the sympathetic nerves and the muscles showed a proliferation of the interstitial connective tissue, with partial atrophy of the proper substance of the nerves and muscles. The entire arterial capillary network of the

nerve centres and of the peripheral nerves showed dilatation, aneurismic enlargement and infiltration of their walls. Paralysis agitans may, therefore, be considered an organic disease of the nervous system closely related to the phenomena of senility, though traces of it are occasionally found in youth. It is always a slowly progressive disease, leading finally to a fatal issue.—*Centralbl. für Nervenheilkunde*, August, 1890.

**FUNCTIONAL AFFECTIONS OF THE GASTRO-INTESTINAL MUSCLES.**—The gastro-intestinal muscles possess two mechanical qualities: (1) tonic, to regulate the calibre of the intestines; and (2) peristaltic, to move forward the intestinal contents. Their activity may be disturbed in two ways: (1) atony, insufficient tone from relaxation of the muscles and enlargement of the calibre of the intestines; and (2) hypertonicity, excessive tone giving rise to spasm and contracture, thus narrowing the calibre of the intestines. Disturbances of peristalsis appear according as accelerating or retarding influences emanating directly from the cerebro-spinal centres or by reflex action may set in. These troubles may be manifested by hyperkinesis (increased peristalsis) leading to diarrhoea, or by akinesis (retarded peristalsis) leading to more or less obstinate constipation. Dissociation between the anomalies of the intestinal tonus and the peristalsis may exist, so that the intestines may be atonic and the peristalsis normal or even excessive, or there may be hypertonus associated with tardy and languid peristalsis. The latter form, hypertonus with akinesis, is mostly found in neurasthenic patients with enteroptosis. With atonic intestines, akinesis usually exists, but intermittent hyperkinesis is possible. In such cases the stomach is often atonic. The type of such patients with neuro-muscular disturbances of the intestines is seen in persons suffering from constipation with prominent abdomen, and suffering off and on from diarrhoea and dilatation of the stomach. Where the intestines are habitually hypertonic the stomach is mostly atonic. This we meet in neurasthenic patients, with flat abdomen and retracted intestines, suffering from obstinate constipation, but easily reacting to a mild laxative. When the stomach is atonic without akinesis, we meet general atonic dilatation, often with good digestion; or there may be atony with akinesis in connection with dyspepsia, gastralgia, flatulence, pyrosis, etc., on account of the stasis of food and abnormal formation of chyle. In normal tonus with akinesis we may meet dyspepsia, but not dilatation. Intestinal spasms with diarrhoea may lead, in acute cases, to a transitory obstruction with painful distension. Disturbances of tonus are less dangerous than are those of peristalsis.—*L'Union Méd.*, 28, 1890.

**DEGENERATION OF THE HEART IN DIPHTHERIA.**—Moesler and Rosenbach found in their patients who died from diphtheria, more or less extensive degeneration of the muscular substance of the heart, especially marked in the vicinity of the endo- and pericardium. Eertel found in cases of severe diphtheria bloody extravasations and accumulations of cells between the cardiac muscular fibres. When death took place from cardiac paralysis the organ was soft and friable, the muscular fibres being found in a state of advanced fatty degeneration. In infectious diseases, Guttman found parenchymatous dulness of the muscular fibres, but no myocarditic foci. In Prof. Orth's clinic there were held last winter thirteen autopsies on patients dying of diphtheria, and in which Schemm noticed the following changes in the heart: Fatty and granular degeneration of the muscular fibres, swelling and decrease of the nuclei, slight hyaline degeneration and atrophy; the connective-tissue somewhat increased, and in some cases the cardiac muscle interspersed by blood extravasations. Age did not seem to exert any particular influence on the intensity of the phenomena presented; they were found in the young and the old alike. Of greater influence was the duration of the disease. The most severe degenerations were found in those in whom the disease had lasted from ten to eighteen days: and the slightest in cases that succumbed early from laryngeal stenosis. The changes in the heart did not bear any relation to the changes in the lungs. Many cases of broncho-pneumonia showed no changes in the heart; others showed no pneumonia but a high grade of cardiac degeneration. The fever cannot be assumed to be the cause of the cardiac complication, for in most cases the temperature did not go very high; and in the worse cases the temperature remained normal throughout the entire course of the trouble. Orth calls this state a *myocarditis parenchymatosa seu degenerativa*, and says that it may be found in grave cases of infectious diseases other than diphtheria.—*Allgem. Med. Centr. Zeitung*, 63, 1890.

**A NEW DISEASE.**—Ehler observed, at the clinic of Prof. Charrin, two children who suffered from a very peculiar disease. Both patients suffered from high fever

and diarrhoea; the urine was highly albuminous. On the twelfth day of the disease, numerous large blisters filled with sero-purulent blue matter appeared. Examination showed that it was the bacillus pyocyanus that caused this bluish coloration. One of the children died; at the post-mortem examination this microbe was found in the blood removed from the heart. Similar cases were observed by Neumann, of Berlin, in two patients who died from grave enteritis and with intestinal hemorrhages. Blue pus has been found several times in febrile diseases, especially in inflammatory affections of the joints.—*Allgem. Med. Centr. Zeitung*, 20.

**MEDICATED SOAPS.**—Eichhoff in treating of this subject says that medicated soaps are indicated in all affections in which the skin is rich in fat, either in association with an excessive deposit of fat in the subcutaneous cellular tissues or with the normal or increased secretion of fat from the sebaceous and sudiferous glands. The soap forms an emulsion with the superfluous cutaneous fat, and this is readily removed by hot water. Let us remember also that only soaps can penetrate into the recesses of the cutaneous glandular organs where the parasites usually dwell.

- To treat dermatoses with soap, then, is more effectual than with salves; it is, furthermore, more cleanly, cheaper and safer. Medicated soaps may be (1) alkaline, with a plus of free alkali; (2) neutral, in which all the alkali is combined with a fatty acid; (3) acid soaps. Eichhoff's soap treatment consists (1) simple washing with soap; (2) rubbing in of the lather with woollen rags; (3) allowing the foam to dry in; (4) fixing the foam by an impermeable bandage. All this can be combined with massage, and these together will do good service in the treatment of rheumatoid affections, neuralgic and the removal of small tumors and exudations. To a well prepared soap Eichhoff adds lanoline two per cent., and olive oil three per cent. Soap should consist of three-fourths pure tallow and one-fourth olive oil, which, with the necessary quantity of soda lye, constitutes the base of all medicated soaps. In obstinate prurigo universalis the author witnessed most excellent results from the use of a five per cent. menthol soap. As a hygienic soap for universal use in health he recommends thymol soap, two per cent. In many chronic skin affections he used a soap containing three per cent of menthol and five per cent. of eucalyptol.—*Volkman's Klin. Vortrage*.

**CARDIO-VASCULAR VERTIGO AND ITS TREATMENT.**—This form of vertigo is often found at the onset of arterio-sclerosis, the symptom complex being that of cerebral thrombosis. In the beginning the patient complains of ill-defined symptoms, hardly severe enough to require him to consult a physician. It is a trouble not infrequently met with. The vertigo of arthritic and rheumatic patients, or those occurring in consequence of excessive indulgence in alcohol, tobacco, etc., belong to this class. Prophylaxis is the main element in treatment.

Cardio-vascular vertigo is a chronic affection characterized by occasional exacerbations coming on without assignable cause. It may supervene on symptoms arising from other conditions, as hemiparesis, amnesia, lassitude, aphasia, etc., and may lead even to epileptiform seizures or fainting spells. The diagnosis must be based upon the concomitant symptoms. It must be carefully differentiated from the vertigos arising from gastric, ophthalmic and aural disorders. The patient complains of a sensation of dyspnoea during exercise, of præcordial anguish, sensations of coldness in different portions of the body, headache, somnolence. Its most characteristic symptom is the increased diastolic sound of the aorta.

In the treatment of this affection the tension of the blood vessels must be regulated either by the iodide of sodium or nitro-glycerine. The former should be given in doses of one gramme daily, and its use steadily continued for months. Grasset prescribes a solution of ten parts of the iodide of soda in three hundred parts of water, a tablespoonful to be taken morning and evening in milk or beer. Nitro-glycerine is, however, the great remedy for diminishing the arterial tension. A one per cent. alcoholic solution is prepared, and of this four drops are given, morning and evening, for twenty days of the month. During the remaining ten days, the iodide of soda is administered. A strictly hygienic mode of life must be followed; high living should be strictly forbidden; milk, the leguminose, and some tender meats, should be insisted upon by way of diet. Fresh air is important. Should malnutrition exist, arsenite of soda may be prescribed with advantage.—*Semaine Medicale*, 31, 1890.

**ERYTHEMA PODOSUM WITH ULCERATION.**—A.W. Hoisholt reports the case of a lady, aged 60, in whom the characteristic papules and tubercles of erythema no-

dosum developed rather suddenly in crops upon the dorsum of one and then the other hand. She had never suffered from rheumatism. On the right hand, which was affected first, the lesions coalesced to form a large abscess from which a table-spoonful of pus was evacuated by incision. The other lesions formed pustules that healed without incision. The diagnosis was based upon the following symptoms: The eruption was symmetrical and painful; absence of itching; the circumference of the lesions blended imperceptibly with the surrounding tissues; at their centre there was a bluish-red depression; they appeared in crops.—*Monatshfte für prakt. Dermatol.*, Bd. II. No. 5.

**ON THE INFLUENCE OF OXYGEN INHALATIONS ON THE VARIATION OF THE RESPIRATORY RHYTHM IN DIPHTHERITIC PATIENTS.**—In the Children's Hospital M. P. Langlois has experimented on children with infectious diphtheritic angina, without the existence of a false membrane in either the larynx or the trachea, and on those that presented all the symptoms of croup before and after tracheotomy. About thirty litres of oxygen were used for each case within from twenty to twenty-five minutes. The respiratory tracings were taken by means of Marey's double cardiograph. The modifications of the form of the respiratory movements under similar circumstances, had been studied already by Ledoux-Levard (*Recherches sur la Respiration dans le Croup*, Thèse, 1881), and the author paid special attention to the variation in the frequency of the same movements. Acceleration of the respiratory rhythm during the oxygen inhalations was observed as a constant result. It begins with the inhalation and lasts as long as this is maintained. Though the frequency of the respiration is increased, it is of a less dyspnoic character. Both inspiration and expiration are more brisk and energetic, and performed with less difficulty. The child is more in a condition of polypnea than of dyspnea. The acceleration of the respiratory rhythm caused by oxygen inhalations seeming to be in contradiction with Rosenthal's statement of the rôle of anoxemia as an exciting agent of the respiratory centre. M. Langlois explains as follows: Under the influence of prolonged subasphyxia depending upon laryngeal stenosis, and perhaps upon the specific action of the secreted septic product of the diphtheritic micro-organisms, the entire organism, and the bulbar centres particularly, are oppressed, which causes diminution in the respiratory incitations. But, under the influence of the inhaled oxygen, the superoxidation of the blood diminishes the vital depression, and the child reacts quickly in resuming sufficient pulmonary ventilation.—*New York Medical Journal*, August 2, 1890.

**THE MORTALITY OF WIDOWERS FROM PHTHISIS.**—In a paper on "Tuberculosis in Belgium," MM. Destree and Gallinæerts come to the conclusion as the result of their investigations, that, in comparing the mortality from phthisis of bachelors, married men and widowers, the last are very much more subject to the disease than either of the other classes. The same statement holds good for all ages, and it is, they say, also true that widows are more liable than single women to die of phthisis. They cannot think that the irregularities and excesses indulged in by widowers can be answerable for it, for advanced age does not seem to make any difference. They would ascribe it to infection occurring during married life, the disease claiming its second victim some time after the death of the first.—*The Lancet*, August, 1890.

**SPIROMETRY.**—M. Joal of Mont Dore has made a number of observations in spirometry that led him to the conclusion that many nasal and pharyngeal affections produce a distinct diminution in the capacity of the lungs. Thus, in cases where hypertrophic rhinitis, adenoid tumors of the naso-pharynx, chronic coryza, etc., have been cured, the capacity of the lungs, as measured by the spirometer, is frequently increased by a quarter, and occasionally even doubled. M. Joal has frequently found that public singers, when they complain of fatigue of the voice or of diminution in its power or range, are suffering from some, perhaps quite unsuspected trouble in the nose or pharynx, and that, if this is cured, the voice recovers itself completely. He suggests that professional singers should know their own respiratory capacity, and that this should be occasionally tested, so that any diminution may serve to give a warning of possible mischief in the nose or pharynx which, if attended to in time, may be met by appropriate treatment.—*The Lancet*, August 2, 1890.

**THE RELATION OF ALBUMINURIA TO MENTAL AFFECTIONS.**—1. Albuminuria may appear during the course of a mental affection as a symptom depending more

or less directly upon a lesion of the nervous centres. The lesion either causes albuminuria comparable to that taught by Claude Bernard, or the filtration of albumin causes changes in the kidneys similar to those of the nervous centres causing the mental disorder. 2. Albuminuria arises from a lesion of the renal filters, causing an auto-intoxication, and thus, in predisposed subjects, becomes the cause of psychic disorders or aggravates a psychic trouble in its stage of evolution. Dieulafoy published such cases under the name of *folie Brightii* (acute mania with hallucinations and vociferations, lypemania, deliria of persecution and erotic and religious deliria), and came to the conclusion that the insanity, often but transitory, depends upon the morbus Brightii. By treating the latter with milk diet and with remedies removing the morbid state of the kidneys, the mental symptoms will also disappear. We meet such cases in persons having a hereditary neuropathic tendency. During the stage of delirium it may be necessary to put them in an asylum, notwithstanding the transitory character of the mental disorder and their origin in renal disorder.—*Semaine Medicale*, 26, 1890.

**RHEUMATIC NEURALGIA TREATED BY HYPODERMICS OF SULPHURIC ETHER.**—The use of hypodermic injections of sulphuric ether as excitants is old; but Dr. Kuma, of Antwerp, is the first to make use of the drug in this way for its analgesic and curative effects. He uses a gramme of the drug at a dose. One may use in its place "Hoffman's Drops," consisting of equal parts of alcohol and sulphuric ether. The injection should be made close to the spot which is the seat of pain, and should be followed by prolonged local massage in order to spread the fluid, and to prevent any induration at the point of administration. He has thus cured radically and promptly neuralgia of the shoulder, wry neck, sciatica, rheumatic neuralgia of the head, of the face with toothache, etc. He once cured a severe gastralgia with severe eructations, which gave no relief to the pain, by means of ether hypodermically. This method is to be commended as superior to injections of morphine as commonly used, as it is entirely free from danger.—*Semaine Medicale*, 24, 1890.

**PROLONGED SOMNOLENCE.**—Mauthner has called attention to the sleeping disease of negroes endemic at Senegal. Without any rise in temperature they suffer from progressive muscular weakness, which lasts two or three months and then passes away; there is muscular paralysis, but sensibility remains intact. Haltenhoff and Gerlier, of Geneva, in 1887, described a neurosis characterized by headache, vertigo, great muscular debility, and loss of the eyebrows. During the onset of the disease the patient is unable to open his eyes or hold anything in the hands. There is no paralysis, and though the disease may last several months, most patients get well. Such cases probably arise from some miasm. Gayet and Mauthner have described cases arising from fright followed by diplopia, vertigo, and irresistible desire to sleep. The "Nona" belongs to the same class. This trouble must not be taken for coma, for when the patients are awakened the mind is perfectly clear. In all such cases there is present a polioencephalitis, an alteration in the central gray substance of the ventricles, the symptoms of which are apathy, weakness, and somnolence, running an acute, chronic or sub-acute course. Acute hæmorrhagic polioencephalitis is localized in the superior part of the gray substance, killing in from eight to fifteen days. At the autopsy the only macroscopic change is a rosy color of the gray substance about the third ventricle; but the microscope readily reveals the hæmorrhages and the histological changes.—*Semaine Medicale*, 24, 1890.

**ARSENICAL PARALYSIS.**—Dr. Conrad Alexander observed in a case of arsenical poisoning symptoms resembling those of peripheric neuritis. He experimented then with rabbits and found that as a result of arsenical poisoning they suffered from lesions of the peripheral nerves, whose axis cylinders were degenerated and atrophied, especially in the finest ramifications of the skin and muscles. Their perinæum showed small hæmorrhages, while the spinal cord was perfectly sound. He considers this state a necrosis by coagulation, caused by a lesion of the arterioles. All the muscular and nervous lesions may only be consecutive to troubles of the circulation.—*Bull. Medical*, 42, 1890.

**AN EPIDEMIC OF CUTANEOUS TUBERCULOSIS SPREAD THROUGH RITUAL CIRCUMCISION.**—Dr. Koltzoff, of Yyalta, details nine cases of cutaneous tuberculosis arising in Hebrew infants circumcised by a phthisical ritual operator. In every

one of the little patients, in about four or five weeks after healing of the preputial wound, the cicatrix (always somewhere near the left side of the frenulum) broke down to transform into one, or several, painful pale ulcers with moderately indurated edges and base, uneven floor of a grayish color, and a very scanty, thin discharge containing tubercle bacilli. The induration was always far from being uniform, the edges consisting of a series of irregular nodules or elevations. In some of the cases, the glans became simultaneously studded with numerous minute, grayish, soft ulcers, showing a pronounced tendency to rapid spontaneous healing. Shortly after the appearance of the ulceration, this or that inguinal gland on the left side became inflamed and suppurated, the process subsequently spreading to other individual glands in the same region. In one of the boys lymphangitis was also observed. Two of the patients died (one from consecutive pulmonary tuberculosis, the other, seemingly, from a kind of chronic pyæmia), the remaining seven making a good recovery.—*British Journal of Dermatology*, October, 1890.

**A CASE OF POISONING WITH FILIX MAS.**—A young woman had just recovered from an attack of perityphlitis when, on account of tænea, she received the usual two doses of filix mas, followed by castor oil. In the afternoon she complained of general malaise, headache, colic and diarrhœa; pulse, 144; temp., 104°. During the night she had severe hiccup and eructations, which continued uninterruptedly for forty-eight hours, with fear of suffocation from the diaphragmatic spasm. She felt as if some foreign substance compressed the trachea; face collapsed and yellow; sensorium benumbed. The next morning she was unconscious; dysphagia; when consciousness returned she complained of blindness; pupils failed to react to light; eyes soft; cornea can be touched without causing any reaction; heart's sounds imperceptible; death momentarily expected. Ether and camphor were injected repeatedly till she rallied. On the fourth day the amaurosis gradually yielded; the urine lost its albumin and recovery followed.—*Münch. Med. Wochenschrift*, 32, 1890.

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## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

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**THE TREATMENT OF INVERSION OF THE UTERUS.**—Dr. J. Kocks has invented a modification of Braun's colpeurynter, which appears to be an excellent instrument, theoretically, for the reduction of chronic inversion. It consists, essentially, in having the colpeurynter made so that, on one side there is a cylinder-like bag projecting on the surface about two and a half inches high and two inches, or a little less, in diameter. When applied to the inverted fundus uteri, this bag folds back into the colpeurynter, and over the fundus, like a cap; at the same time the whole instrument surrounds the inversion and distends the vagina at the ring of constriction, as well as pushing up the fundus, when water is forced into the bag. Furthermore, it is claimed, that as the fundus goes up through the cervix the small bag is everted and will follow up the fundus uteri. (I have not seen the instrument used, and cannot speak from experience. It is described in the *Centralblatt für Gynäkologie*, No. 37, G. R. 8., 1890.)

**ANTISEPSIS IN NORMAL LABOR.**—Verchère is of the opinion that the ordinary methods of antiseptics in labor are not sufficient. He advocates vaginal irrigation twice a day with 1:1000 corrosive sublimate solution for four weeks previous to delivery, with the exception of the last week, and then only every second day, with a tampon of iodoform gauze in the vagina between the irrigations. The tampon is removed when the labor pains begin, an examination made, and another tampon inserted which remains till expelled by the advancing head. When labor is finished, the vagina is washed out with a sublimate solution and a tampon again inserted, which is removed on the next day. Tampons are removed afterward every second day, and finally every third day. An iodoform or sublimate compress is kept on the vulva. He states that this procedure is followed by absolute apyrexia in all cases, with less excretion from the genitals, no milk fever or purulent lochia. Blood is seen only on the first day, and on the second there is a bloody, serous fluid, and but little serum on the third day.—*L'Abeille Méd.*, No. 9, 1890.

**THE ABUSE OF THE INTERNAL DISINFECTION OF HEALTHY WOMEN.**—C. Axmann reports his thirty years' experience as director of the Erfurt Lying-in Hospital, and condemns the internal use of sublimate and carbolic acid in healthy women. "Cleanliness, rest, and the avoidance of meddlesome and excessive interference, as well as every kind of chemical disinfection, are the only correct principles of treatment." In 1187 women, used for purposes of instruction, only 46 had an elevation of temperature. In the city, where women were attended by midwives, there was a mortality of 3.26 per 1000, and 128 per 1000 from childbed fever. —*Centralblatt für Gynäkologie*, No. 37, 1890.

**EXTERNAL VERSION WITH THE SECOND TWIN.**—Strassman states that with 111 transverse presentations of the second twin, spontaneous version occurred six times, spontaneous evolution twice, and internal version was performed ninety-two times. External version was attempted eight times. Dr. Brosin, of Dresden, warmly recommends external version, as it is very easy to perform, and avoids the increased danger of infection from the introduction of the hand within the vagina and uterus. —*Centralblatt für Gynäkologie*, No. 36, 1890.

**MORPHINE AND ANTIPYRIN IN MILK.**—Pinzani experimented with twelve nursing women, giving them for six successive days 3-5 cg. morphini hydrochlorici. They nursed thirty infants, one of them prematurely born and kept in a "Correuse." None of the infants were affected, and though the milk was very carefully tested, no trace of morphine could be found. The same writer found that antipyrin taken by nursing women did not alter the secretion of milk, but that it passed into the milk in very small doses, and the infants suffered from colic and diarrhœa. Antipyrin taken in labor diminished the uterine contractions. —*Centralblatt für Gynäkologie*, No. 36, 1890.

**THE MANAGEMENT OF LINGERING LABOR.**—A discussion on the modern methods of managing lingering labor before the British Medical Association was opened by Dr. W. S. Playfair. After referring to the dread of meddlesome midwifery, on the part of leading obstetricians of thirty-five years ago, and the readiness with which these same men resorted to bleeding and debilitating medication, the speaker proceeded to review the methods of the present day. The mere wear and tear of a labor lasting more than twenty-four hours seemed to him to be a very serious thing, and he did not think it right that we should sit with hands folded waiting until serious symptoms should arise before taking action. He first considered the frequently met with difficulty arising from non-dilatation caused by inertia, or by irregular and cramp-like pains, premature rupture of the membranes, and over-distension of the uterus from excessive liquor amnii. For the relief of rigid os uteri prolonging the first stage of labor, Dr. Playfair advocated most strongly the internal administration of chloral hydrate. Under the use of this agent the pains become longer, steadier, and more efficient. The patient falls into a somnolent condition dozing quietly between the pains, which are not lessened or annulled as when chloroform is used. The wild state of excitement is calmed and soothed. Fifteen grains should be given at the first dose, repeated in twenty minutes. Possibly a third dose may be required, but never more.

As an oxytocic Dr. Playfair recommended quinine. In a labor with feeble ineffective pains, one or two doses of quinine of fifteen grains each, will have a beneficial effect in altering the character of the pains. This drug does not possess any of the dangerous properties of ergot.

Speaking of mechanical means for producing dilatation of the os, the speaker referred to a suggestion first made by Trenholme, of Montreal, that the finger be swept around the inner surface of the os, separating it from the membranes. Why it is so Dr. Playfair did not know, but he was satisfied that this simple procedure did excite marked dilatation of the os.

When the head is pushed down low in the pelvis, the os being soft and relaxed, and the membrane ruptured, it was his belief that gentle manual dilatation, pushing, as it were, the os over the head, is frequently extremely useful. Pushing up the swollen anterior lip when impacted between the head and the pubes is not only legitimate but essential to save injury to the os.

In prolonged second stage, Dr. Playfair referred to ergot, and condemned its use at this time in the strongest terms. The only oxytocic he would recommend at this period of labor was manual pressure applied over the uterus to increase the pains when they are feeble, or to take their place when they are absent. The best



way of using it is for the practitioner to stand by the side of the patient, and to spread his left hand over the fundus. When the pain comes on, strong downward pressure is made in the direction of the axis of the brim. If the finger of the right hand be placed simultaneously on the head, *per vaginam*, it will be felt to be pushed down in a very marked way. One may often push a head through the brim where it has been delayed for hours and on to the perinæum in two or three pains. One may often thus avoid the use of forceps.

As to the latter means, the speaker expressed the fear that there was a tendency to use the instruments too frequently. In the period from 1815 to 1821, 21,867 cases of labor were treated at the Rotunda Hospital, Dublin, without the forceps having been used once. The present practice in this institution is such that forceps are now used on an average of 1 in 16.5 cases. The use of the forceps when the head is high up is a serious operation always, and should not be undertaken lightly.

Unnecessary delay, when the head is in the pelvic cavity, is not only useless but pernicious. By timely interference we lessen the risk to both mother and child. It is quite impossible, however, to lay down any precise rule as to when the forceps should be used in lingering labor. Every case must be treated on its merits, after a careful examination of the effect of the pains.—*British Medical Journal*, September 27, 1890.

**TWENTY-EIGHT AUTOPSIES OF SYPHILITIC STILL-BORN INFANTS.**—M. Barthelémy found that most of the infants presented no lesions, visible either to the unaided eye or to the microscope. These infants were killed by the syphilitic virus without there being any alteration of the organs, just as may happen in variola. In five cases there were gummata visible, affecting in three cases the liver alone; in one case, the liver, tibiae, and clavicles, and once the thymus also. In eight other cases, in which there were no gummata apparent, the liver in five cases presented a granular appearance, and in those cases the microscope revealed the presence of miliary gummata of the liver and kidneys. No lesions of the spleen were noticed in any case, except that that organ was generally larger than normal.—*British Journal of Dermatology*, October, 1890.

**THE USE OF ELECTRICITY BY THE GYNÆCOLOGIST.**—In a paper on the above subject, Dr. A. F. Currier said that the faradic current is indicated when one desires increased muscular tone or contractile force. Incidentally will come improved vascularity and nerve energy. The galvanic current is indicated as an astringent, hæmostatic, denutrient, adnutrient, or sedative. For some conditions, pain for example, either current may be effective. For an abdominal electrode, Martin's is the best. There are many varieties of vaginal and uterine electrodes, those designed by Apostoli being very good ones. The character and effect of the current at the two poles are essentially different. The positive pole will check hæmorrhage and glandular secretion; the negative will not. The positive pole is acid; the negative alkaline. For pain the positive pole should be within the vagina or uterus, and a weak current is better than a strong one. A good average is thirty milliamperes, used from five to eight minutes. The intervals of application should depend upon the periods in which pain is absent. For hæmorrhage the positive pole is believed to be unsurpassed. In five cases sterility was treated with the faradic current. Impregnation and delivery resulted in two. Dysmenorrhœa may be relieved by either the positive galvanic pole or faradism. For supercretion the positive pole is preferable to powerful escharotics and caustics, and yielded good results in three cases. In two cases hysterical symptoms were much modified in addition to benefit which was derived from more palpable lesions. Subinvolution was successfully treated in one case, the uterus contracting firmly upon the bipolar electrode of Apostoli, and with the faradic current. Uterine subnutrition in connection with hardantiflexed uteri and usually associated with amenorrhœa, dysmenorrhœa or sterility, will be benefited by the faradic current.

Under the head of cautions, the author remarked that nausea resulted from the applications in one case. The passage of the galvanic current may cause faintness. An irritable heart contraindicates the use of electricity. Malignant disease within the abdomen was a contraindication in one case. Small dry electrodes should not be applied to the abdomen, but large wet ones. The former will invariably produce burning. The method of rapid reversals of the galvanic current is of limited utility, and should not be used with nervous women. The electro-puncture of fibroid tumors means possible sepsis. If it is electricity and not inflammation and sloughing which reduce the nutrition of the tumor it would seem to be unnecessary. Electropuncture is also disapproved of for hæmatoma and hæmatocele as dangerous, tedious and inefficient in its results.—*New York Med. Journal*, October 18, 1890.

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**LOOK BEYOND THE NOSE**—There is a tendency, more especially upon the part of those who have had insufficient experience in general medicine—or, perhaps, not any—before undertaking exclusive practice, to magnify the importance of local lesions coincident with general disorders of the system, or with local disease in some other region. Dr. S. S. Cohen, after citing cases illustrative of this statement, concludes as follows: "There are conditions of headache and other nervous disturbances, including asthma, dependent doubtless on nasal lesions; but men, at least those who, like myself, are in active general practice, meet with a far greater number of cases of these conditions in which there is no nasal abnormality, or in which nasal abnormalities are not causative, but merely coincident. Furthermore, all rhinologists must have seen quite a large number of cases of nasal lesion in which none of these nervous phenomena were manifest; as well as many cases in which nasal symptoms themselves were dependent upon systemic causes." The conclusion draws itself; there is no need for elaboration. It is simply this: Let us examine the nose as well as the other organs of our patients, either as a matter of routine, or when special indications are present; let us treat *secundum artem* whatever nasal condition demands treatment; but let us not forget to look beyond the nose.—*N. Y. Medical Journal*, September 27, 1890.

**SUPPURATING ULCER OF THE CORNEA.**—Dr. Edward Jackson advises that the surface of the ulcer be scraped with a blunt instrument, such as the cornea spud, until all tissue soft enough to be readily scraped away has been so removed, and the purulent exudate has been squeezed out from the tissue around it. This manipulation reveals the depth of the ulcer, considerably narrows the area of noticeable infiltration, and enables the surgeon to make his subsequent application directly to the seat of conflict between the living tissue and the invading pyogenic bacteria. The scraping should be repeated whenever any renewed extension of the area of purulent infiltration is noticeable, whether that be six, twelve, or twenty-four hours, and so often as there is this indication for it. Immediately after each scraping, the surface of the ulcer is to be thoroughly washed with a solution of bichloride of mercury of from 1-1000 to 1-3000. This is done by filling the ordinary rubber-bulb pipette or dropper with the solution, holding its nozzle in close proximity to the ulcer, and then ejecting the fluid with considerable force against its surface. In addition, the patient is to have the eye thoroughly cleansed, every one, two, or three hours, with a solution of mercuric chloride of 1-3000 to 1-5000. And two or three times a day the closed lids are to be bathed, for five minutes or longer, with water as hot as the patient can bear. The length of hot applications is to be proportioned inversely to the inflammatory hyperemia. When the general inflammatory reaction seems greatly below what should attend the suppurative process going on in the cornea, each application of hot water may be continued for fifteen to twenty minutes, or the application may be more frequently repeated. The pain of this scraping and washing may be brought within reasonable limits by the use of cocaine. Corneal abscess is to be opened freely, and treated in the same way. Poulticing and bandaging are to be avoided. As the ulcer loses its special suppurative character the treatment is abandoned, except that the use of the milder solutions of mercury is continued until the healing is nearly completed.—*Times and Register*, October 4, 1890.

**PYOKTANIN OR ANILINE VIOLET.**—The result of continued investigation in regard to the virtue of pyoktanin has brought about somewhat contradictory announcements.

These seem to show that it is not of such service in the treatment of diseases of the eye, for which it was at first so highly recommended; but it appears as though there were conditions for which it has decided usefulness.

Dr. J. Scheinmann, of the university throat clinic of Berlin, reports some very remarkable results of the use of pyoktanin in the treatment of tuberculous ulcerations of the larynx and the nose. As an application to these ulcers it has proved absolutely unirritating and has been followed by rapid cicatrization. The action is easy to follow and to limit, as the remedy has such powerful staining property.

Usually the ulcers, after two or three days, show lighter coloration and a decided improvement. The action of the pyoktanin is entirely painless.—*Medical and Surgical Reporter*, Sept. 27, 1890.

**BLENNORRHOEA OF INFANTS.**—Dr. Grossman (Liverpool), in considering the prophylaxis of infantile blennorrhoea, proposes the following three resolutions to the British Medical Association:

1. Each midwife ought to be instructed during her time of apprenticeship about the symptoms and treatment of infantile ophthalmia. This ought to be noted on her certificate.

2. In every case where the signs of an inflammation of the eyes occur during confinement, the midwife should be compelled to give notice to a medical man (in case of the poor, to the parish doctor) or some other authority.

3. In case the midwife omits any of these points, her certificate should be withdrawn or a fine imposed.—*American Journal of Ophthalm.* Sept., 1890.

**MUSCULAR INSUFFICIENCY.**—At the late meeting of the British Medical Association during the discussion on latent strabismus, Javel stated that an astigmatism was usually the cause of asthenopia and latent strabismus, and Roosa, of New York, asserted roundly that muscular insufficiency had no existence, but was always an effect of astigmatism. Landolt, Hirschberg and Stevens protested against these views and asserted their belief in a pure muscular asthenopia.—*American Journal Ophthalmol.*, Sept., 1890

**ABNORMAL OPENING INTO THE MAXILLARY SINUS IN A SYPHILITIC WOMAN.**—Hermet reports an interesting case of a prostitute, age 27, who was suddenly attacked by peculiar hysterical symptoms with a turning of the whole body towards the right, roaring and whistling in the ears and right-sided deafness. When these attacks ceased all of the molars of the left upper jaw were found to be loose, and the patient removed them herself. The opening into the maxillary sinus caused by the removal of the roots of the teeth did not close again.—*Monatshefte für prakt. Dermatol.*, Bd. II. No. 5.

## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

**COFFEE AS AN ANTISEPTIC.**—During hot weather coffee is an excellent disinfectant to purify the air in the sick room and prevent infection. It furthermore has a pleasant aroma, and is without danger, a thing that cannot be said of chlorine or carbolic acid. Coffee roasted and ground dissipates animal and vegetable effluvia and renders them innocuous. Barbier, of Algeria, relates that as coroner he was called to a tavern where the night before a man had been killed. He and the jury were led to a room where the corpse lay, but the stench was so unbearable that no one could enter. Some roasted and ground coffee was then thrown over the corpse and also on the floor. This dispelled the foul emanations, so that the jury could perform their duties. Barbier witnessed the same effect of coffee on the body of a child that had been in the water a week. He has also seen good effects from its application in the treatment of putrid ulcers. Ice boxes often take on a foul odor when meat or fish are kept in them. A sprinkling of some ground coffee in them will cause the odor to disappear. By sprinkling game with coffee it may be kept fresh for several days. The antibacillary action of coffee seems to be well-established.—*Allgem. Med. Centr. Zeitung*, 64, 1890.

**THE CURE OF INSANITY BY SURGICAL OPERATIONS.**—It is well known that insanity can be caused by traumatism. French alienists have shown that the converse also holds good, and that insanity may be cured by traumatism. Gauran, of Rouen, reports the case of a woman suffering from melancholia, who, after an operation for cataract which she had from early infancy, remained free from her delusions. The operation restored her sight. Seglas reports a similar case, that of a woman with active melancholia, who was operated on for an ovarian cyst. When she recovered from the effects of the anæsthetic all delirium had disappeared, and this sudden recovery remained permanent.—*Progres Medical*, 32, 1890.

**COELIOTOMY.**—Harris, in a recently published pamphlet, discusses the impropriety of the word laparotomy to indicate an incision through the abdominal walls in general, and the propriety of substituting for this term coeliotomy, which is etymologically correct.—*Medical and Surgical Reporter*, September 13, 1890.

**RESECTION OF THE LIVER.**—Terrillon reported to the Paris Academy of Medicine the case of a woman who presented a good-sized tumor in the right hypochondrium. Aspiration withdrew a fluid like that found in hydatids. Laparotomy revealed a portion of liver tissue, about the size of two fists, riddled with small hydatid cysts. There being no pedicle, a rubber tube was placed between this mass and the normal liver tissue. An artificial pedicle was thus formed, which was fixed in the abdominal wound. The mass was resected at the end of eight days and the tubing removed. The wound healed by granulation in six weeks, the patient rapidly gained flesh, and is now in excellent health.—*L'Art Medical*, September, 1890.

**PERFORATING WOUND OF THE HEART.**—Dr. Stimson presented a heart to the New York Surgical Society that had been taken from an Italian who had been stabbed in seven places, in the chest, abdomen and arms. He was brought to the hospital in a state of profound shock, so that surgical interference was not deemed justifiable, and he died eighteen hours later. The knife had penetrated the wall of the chest an inch to the right of the left nipple, and perforated the right ventricle, making a wound one-quarter of an inch long in its anterior surface, and one-third of an inch below the anterior cusp of the semi-lunar valve of the pulmonary artery, and just puncturing the opposite wall an inch and a half from the posterior interventricular septum. The valves and the chordæ tendinæ were uninjured.—*New York Medical Journal*, September 20, 1890.

**BACTERIA FOUND IN THE SAC OF STRANGULATED HERNIA AND THEIR RELATION TO PERITONEAL SEPSIS.**—Bonnecken, in a series of observations in man and experiments on dogs, found in the fluid of the sac of strangulated hernia, bacteria in great numbers, which were identical with those present in the intestinal canal. A venous stasis or an infiltration of the serous coat of the bowels is sufficient for the escape of micro-organisms from the intestines. In fifteen cases he found Miller's *Micrococcus arogenes*, Escherich's *Streptococcus coli brevis* and *Streptococcus coli gracilis* eleven times, besides numerous others. In the earlier stages of strangulation micrococci alone were found, whereas in those of longer duration he also found bacilli. As a result of his experiments, he came to the following conclusions.

1. In the hernial water of strangulated hernia previous to gangrene, numerous bacteria are present.
2. These micro-organisms pass through the intestinal walls.
3. Death caused by an artificially produced strangulated hernia in animals is due to peritoneal sepsis.
4. The sac as well as the strangulated bowels should be most thoroughly disinfected before being returned into the abdominal cavity.—*Virchow's Archives*, Bd. cxx., heft. 1.

**THE PRODUCTION OF PERITONEAL ADHESIONS BY COLLODION AND THE FIXATION OF MOVABLE KIDNEYS BY IT.**—In an investigation of the causes of peritoneal adhesions, Dr. v. Dombowski found the simplest and surest method of causing a circumscribed adhesive peritonitis was to paint the peritonæum with a solution of collodion or collodium. If care is taken to keep the painted place at rest, the folds of peritonæum in contact with it will unite.—(*Archiv f. Klin. Chir.*, Bd. xxxvii., H. 4.)

Having a patient with movable kidneys which caused her much suffering, Miculicz operated in the following manner: He made an incision in the median line, three inches above and below the navel. The kidneys were brought into the wound and the peritonæum covering them painted with a thin layer of iodoform collodion (1 : 10). As soon as the ether had evaporated, the kidneys were restored to their normal positions so far as possible, and kept there by a firm abdominal compress. For three days the pelvis was elevated. The patient complained of severe pain in both sides for forty-eight hours after the operation. Otherwise, she had a normal recovery. The patient was partially relieved of her suffering and the kidneys were fixed, though some mobility could be felt in certain positions.—*Zeitschrift für Geburtshilfe und Gynäkologie*, Bd. xix., H. 2, 1890.

[The before-mentioned patient died four months after the operation from hyperemesis-gravidarum. At the necropsy, the kidneys were found in their normal position and only slightly movable. The use of the collodion appeared to be successful in every way. Since then, Veit has proposed to treat posterior displacements of the uterus by laparotomy and causing adhesive peritonitis behind the cervix, so as to form extensive adhesions which will keep the uterus in place, without further operating.—*Zeitschrift für Geburtshülfe und Gynäkologie*, Bd. xx., H. 1, 1890.]

**SUBNITRATE OF BISMUTH AS A SUBSTITUTE FOR IODOFORM.**—Casati believes that subnitrate of bismuth is an excellent substitute for iodoform. He claims that it decreases the purulent secretion of wounds in process of granulation; that it encourages granulation; that it never manifests any bad effects; and that it far exceeds iodoform in activity.—*Archiv. für Dermatol. und Syphilis*, Heft 4 u. 5, 1890.

**BERGMANN**, expresses the importance of a careful disinfection of the surgeons' hands in the following words: "Infection by contact with the physician's hands plays a principal part in the etiology of diseases of wounds, and the much prized skilful hand of the surgeon may bring the greatest harm with the tenderest touch."

**OPERATIVE TREATMENT OF GOITRE.**—W. W. Van Artsdalen, in the *Annals of Surgery* for September, 1890, gives a very exhaustive review of the operative procedures employed for the removal of thyroid tumors.

The indications for operative interference are: (1) symptoms of suffocation; (2) dyspnoea, even when occurring after exertion; (3) rapid growth of the tumor; (4) dysphagia; (5) interference with the patient's duties or even enjoyment (Maas); (6) age does not contra-indicate operation.

The following complications may occur during the operation: (1) hæmorrhage; (2) gross lesions of such nerves as the sympathetic, the pneumogastric, the hypoglossal, or the recurrent laryngeal; (3) injuries to the trachea or œsophagus.

The complications which may immediately follow the operation are inflammatory or septic conditions producing aphonia from tumefaction of the laryngeal mucous membrane, or suppurative cellulitis of the neck or anterior mediastinum.

Those appearing at more remote periods are mania, epilepsy, tetanus, hysteria, myxœdema, recurrence of malignant growths *in loco* or at a distance.

The choice of the method of operation will vary in the different forms of goitre (exophthalmic goitre excepted) for large nodes in simple goitres, enucleation; if this be impossible, resection. For nodes in immovable goitres with symptoms of suffocation, enucleation; if this becomes worse, evidently. For soft nodes evident is to be preferred for the sake of dispatch. For numerous small nodes, partial extirpation, if no sound tissue remains, resection. For vascular tumors, ligation of the arteries. For cysts, enucleation. For diffuse hypertrophy, partial extirpation; if no sound tissue can be left, resection. For malignant goitres, total extirpation or amputation. For acute thyroiditis, total extirpation; or if occurring in cystic goitre, enucleation, or, to save time, incision and drainage. For tumors, the nature of which has not been made out or when the chosen operation cannot be done, resection. Injections are used when, for some reason, an operation is not deemed advisable. Of the fluids used, iodine, ergotine, arsenic, iodoform, etc., the latter seems preferable. It has been used (Mostig-Moorhoff) for soft parenchymatous or follicular goitres, iodoform one part, olive oil and ether each seven parts, fifteen to thirty minims being injected (once or twice a week) from five to ten times. A preliminary tracheotomy should not, as a rule, be done.

The operations referred to are described as follows:

**Extirpation (Kocher).** The skin, superficial fascia and muscles are divided and the capsule exposed. The superior thyroid and large veins are tied, the external capsule split and the gland turned out. The inferior thyroid is tied near the carotid, i.e., as far away as possible from the gland, the isthmus isolated and the tumor cut off.

**Enucleation (Socin).** The gland is exposed, its parenchyma excised if necessary and the nodes with their capsules enucleated with blunt force.

**Resection (Mieulicz).** The tumor is freed above by blunt dissection and ligation of the vessels and the isthmus isolated and cut through. The lower attachments are treated like a pedicle, the tumor being split into strands longitudinally which are tied off one by one.

**Amputation (Nussbaum)** differs from the above only in that the artificially formed pedicle is divided with the cautery.

**Evidement (Kocher).** Differs from enucleation only in that the nodes and their capsules are split in two and each half then taken out. It is more rapid.

**Ligation of the Arteries (Woffler).** The superior and the inferior thyroid arteries are tied and the gland shrivels into a cicatricial mass. The ligation presents many difficulties.

**DRY TREATMENT OF OPEN WOUNDS.**—H. T. Byford urges the more frequent use of dry dressings in open wounds and ulcers, the desideratum being asepsis more than antiseptics, and abundant capillary drainage of every and the minutest portion of the wound. To accomplish the latter the drainage material should be changed before it becomes saturated or clogged. Germicides, as a rule, neither prevent nor arrest suppuration in open wounds, hence Nature's method of healing small superficial wounds to be followed, *i.e.*, to dry the wound and keep it dry, or, failing in this, to constantly drain off the accumulating fluids. At each dressing the surrounding surfaces are cleansed, the wound dried off with absorbent material and new drainage applied; in other words, no watery solutions come in contact with the wound. This may have to be repeated frequently for the first few days or until the discharge becomes scanty. Capillary drainage is best obtained by packing into every corner of the wound dry, aseptic (*i.e.*, not impregnated with iodoform, sublimate, etc.), cotton for small wounds, or gauze for large ones, the objection to the continued use of the latter being that the granulations work into its meshes and are torn on its removal. No powder should be dusted on the wound; in short, the absorbent dressing is packed accurately into the wound, so as to allow of no spaces in which discharges can accumulate and serve as media for germ development and the dressings are changed often enough to avoid clogging and consequent damming back of the same with like results.—*Annals of Surgery*, October, 1890.

**THE RELATION OF GONORRHOEA TO RENAL DISEASE.**—Kennedy draws attention to the above subject, which is often forgotten judging from the indiscriminate use of diuretics and the apparent lack of interest taken in the disease. He sums up the following ways in which gonorrhoea may induce diseases of the kidneys: (1) By direct extension of the morbid process through continuity of structure. (2) By interference with the escape of urine, as in stricture. (3) By reflex irritation; the urethral irritation may reflexly disturb the renal function and cause hyperæmia and inflammation. (4) Diuretics, the excessive or injudicious use of which may induce kidney changes.—*New York Medical Journal*, October 18, 1890.

**THE ACTION OF CHLOROFORM ON BACTERIA.**—The experiments of Robin, Munz, Koch and others on the preservative action of chloroform were taken up by Kirchner, who, after a series of interesting and carefully conducted experiments, came to the following conclusions: chloroform is not a disinfectant but an antiseptic and very valuable as a preserving agent. In strong solutions and where evaporation is prevented it is of especial value; it destroys the bacilli of typhoid and cholera rapidly, but does not to any degree affect the spores. When added to infected milk or water in one-half per cent. solution it soon sterilizes the same. The question as to the action of such a solution on the healthy tissues is an interesting one and worthy of investigation. The author recommends it in the above solution for cleansing the field of operation and wounds, especially in those cases where corrosive sublimate and carbolic acid are contra-indicated. He values it above all other antiseptics as a mouth wash.—*Pharmaceutische Rundschau*, October, 1890.

**A HINT ON THE ADMINISTRATION OF CHLOROFORM.**—At a recent meeting of the Académie de Médecine, Dr. Guérin, speaking of the administration of chloroform, stated that he believed the spasms of the glottis, which not infrequently occur in the early stage of chloroform narcosis, are due to the reflex action caused by the irritating action of the drug on the mucous membrane covering the inferior turbinated bones. This irritation is similar to that occurring in inflammation of the nasal mucous membrane, especially of that part covering the inferior turbinated bones, which produces, by reflex action on the larynx, a spasm of the glottis closely simulating asthma. To avert this danger he has for many years been in the habit of closing the nostrils with two fingers of the same hand which holds the sponge, making the patient breathe through the mouth. By this method the nasal mucous membrane is anesthetized only at the same moment that the cornea and other tissues are made insensible and the disquieting and dangerous initial spasm is thus prevented. This procedure seems preferable to the injection of cocaine into the nasal fossæ, which has quite as many dangers as badly administered chloroform.—*Revue Homœopathique Française*.

# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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CONDUCTED BY

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**CARDUUS MARIANUS.**—The main sphere of action of *carduus marianus* is in diseases of the liver, the gall-bladder and the spleen, and in diseases dependent upon organic lesions of these viscera, such as asthma, cough with stitches in the side, and localized rheumatism, particularly of the intercostal muscles, the diaphragm, and the abdominal muscles, also in diseases of the stomach, digestive disorders and gastro-intestinal catarrh. It has a marked action upon the venous system, especially when the disease of the vascular system is due to hyperæmic conditions of the liver and obstructive hyperæmia of the portal system, although it appears to have a specific action on the vascular system independently of any disease of the abdominal organs. Epistaxis, metrorrhagia, bleeding hæmorrhoids, expectoration of blood and hæmatemesis, as well as venous ulcers of the leg, have frequently been cured by the remedy.

The first and main indication for *carduus marianus* is *hyperæmia of the liver*, hyperæmic conditions of the gall passages and of the portal system, and icterus. In hyperæmia of the liver it is as useful in the acute as in the chronic form. Its indications are, more or less marked distension and painfulness of the right hypochondrium, with pressive, throbbing or sticking pain in the right side of the abdomen below the short ribs to the back, also radiating through the chest to the right shoulder. Clinically, it has been found useful in painful diseases of the liver without any accompanying swelling or impaction of gall-stones.

There is a tendency to deep breathing, but the pains are aggravated thereby; they are also aggravated by motion. In very acute cases the affections for which it is useful simulate bilious fever or the so-called acute hepatitis or typhlitis, or the symptoms may call to mind a puerperal peritonitis; or cough, with pain in the side, may be present.

*Chronic hyperæmia of the liver* is often accompanied by chronic stitches in both hypochondria; pain in the region of the cæcum, to which may be added emaciation, muddy color of the face, and even hectic fever. Occasionally, hæmorrhages occur, epistaxis, expectoration or vomiting of blood, metrorrhagia; also pain in the hip and intercostal muscles.

Its indications in *icterus* and *gastro-intestinal catarrh* are, dull headache, particularly in the forehead and temples; dulness of the head; vertigo; epistaxis; bitter, pappy, insipid taste; eructation; heartburn; white tongue, particularly if it is white in the middle and red at the tip and edges; but also if it is only coated on one side; vomiting of a sour, green fluid. In the beginning the stools are mostly brown, and of a hard consistence (normal); later they become light yellow and of a pappy or fluid consistence. At first the urine is a deep yellow, then brownish from bile, cloudy alkaline or acid, with opaline scum and flocculent sediment.

The *gastro-intestinal catarrh* is subacute in character, although attacks of gastralgia may occur when the pains are contractive, with vomiting at their height, and sensation of cold rising from the præcordium to the throat; they end with a sensation of contraction of the throat. It might be mentioned here that the remedy is, at times, useful in the vomiting of pregnancy when it occurs in the morning before any food is taken, and a watery, tasteless fluid is brought up. It has been

recommended in gall-stone colic, but, according to Einsender's experience, the vomiting alone is relieved.

*Melancholia*, due to disease of the liver, has been cured by the remedy when other indications were present. Cough is very seldom absent; it is dry at times, at others there is blood-streaked or bloody expectoration; in the morning, thick yellow sputum is raised with difficulty; there are also stitches in the side and evening fever. The patients also complain of dyspnoea, so that the presence of pleuritis or pneumonia might be suspected before a physical examination is made.

According to the physiological provings of Reil, *carduus* produced the following symptoms: More difficult voiding of stool or absence of stool; dull, frontal headache, particularly towards the right temple; bitter taste; nausea; pressure in the stomach; pyrosis; distension of the epigastrium: white-coated tongue, particularly in the middle; later, distension of the right hypochondrium, with pressure there and pain from deep inspiration and motion. As the dose was increased, the stools became yellow and pappy; vomiting of green, sour fluid; and the urine, which had been deep yellow, became brown and contained gall-pigment, as was demonstrated by chemical tests; it retained its normal acidity. The symptoms persisted for some days after the close of the experiments, and then disappeared spontaneously.

In acute or subacute gastro-intestinal catarrh, where the previously mentioned symptoms were present, *carduus marianus*, in the dose of a number of drops repeated several times daily, proved itself very valuable.

In *gastralgia*, the healing virtue of *carduus* is greater than many of the more frequently used remedies. Brilliant results will be obtained from the use of this remedy if there are present pains of a drawing together (constrictive) character; vomiting at the height of the attack; cold sensation rising from the epigastrium to the throat, in which a crampy, constrictive sensation is felt; pressive, sticking pain in the right side of the abdomen, radiating towards the back or shoulder, together with the *carduus* liver affection. According to Einsender's observations, *cardialgia*, due to some form of liver disease, are more frequently met with than those of a purely nervous character, for which assumption the excellent action of *nux vomica* seems to speak.

Even if *carduus* is not a splenic remedy *par excellence*, it must be placed alongside of conium, the antipsoric of the spleen, acorn waters, and others. It is of value in *chronic hyperemia of the spleen* and affections resulting therefrom. It cures the following symptoms, which are supposed to be due to splenic affections: Chronic stitches in the left hypochondrium; vomiting of blood; intermittent fever and intermittent neuralgias. Einsender frequently saw these symptoms, which had been left as sequelae to malaria or typhoid fever, disappear under the use of *carduus*. In former times *carduus* has been prescribed for malarial fever.

The cases are numerous in which *carduus* has cured stitches in the right side (liver) or in the left side (spleen), with cough and bloody expectoration, or expectoration of tough, lumpy mucus, and evening fever. Even cases of apparent phthisis pituitosa may be cured with it, as well as mild cases of bronchial catarrh.

Hæmorrhages from the lungs that occur in connection with diseases of the liver may be cured by *carduus*. Cough, with expectoration of blood, accompanied by disease of the spleen, in which splenic stitches or swelling of the spleen and amelioration of the symptoms by lying on the left side occur, is curable by *carduus*. Acute and chronic bronchial catarrh, as well as acute and chronic angina faucium, if accompanied by liver or splenic affections, require *carduus*. Even long-lasting asthma, if it is dependent upon liver disease, has yielded to *carduus*.

It has already been mentioned that *carduus* is a very valuable remedy in various kinds of hæmorrhages. One thing is certain, where they are connected with diseases of the liver or spleen, the remedy is able to control them; and it even seems that where these complications are not present, it exerts a curative action. Thus Prof. Rapp asserts that it is curative in *chronic epistaxis*, which in young people is often a symptom of psora, and it is next to bryon. in these cases. Einsender has verified this statement many times (*hamamelis* and *crocus* were also efficacious). Cases have proved its value in cough with bloody expectoration, hæmatemesis, and bloody stool. It must be mentioned that it is also very valuable in hæmorrhages from the uterus. These often occur as concomitants of liver or spleen affections (and renal affections). It is not always possible to prove the presence of liver and spleen diseases by demonstrable swelling and enlargement of these organs, or by the presence of violent pains in them. The existence of a disease of the liver or spleen



is often probable from the patient having suffered from typhoid or malarial fever, jaundice, or pneumonia. This assumption is strengthened by the presence of disturbances of digestion, tendency to diarrhoea or constipation, bitter taste, coated tongue, yellowish coloration of the temples or angles of the mouth, mouldy color of the urine, light-colored stools, sensation of repletion after taking but little food, and sensitiveness of the hepatic region to touch; in diseases of the spleen, color of the face similar to that found in anemia. The extraordinarily good results obtained from the administration of large doses of *bursa pastoris* have already been published by the author. *Carduus* is also valuable in such cases.

The value of *carduus* as a remedy affecting the vessels is proven by the experience of Dr. Windelband, who cured 145 cases of varicose ulcers of the leg out of 196 treated. In Bd. 1, Heft 4 of the *Zeitschr. des Berliner Verein. Homœop. Aerzte*, they have been described in full as having been fully developed ulcerations of a bluish, brownish-red color, with dirty-colored granulations. Around them there was a brownish pigmentation in which varicosities existed. Their edges were notched, callous, bled easily, and a knock against them would usually cause a varicosity to burst. Eczema preceded them (rarely inflammation of the subcutaneous connective tissue), and generally originated from scratching open the itching, eczematous skin. Pain was generally moderate; burning in and around the ulcers was only rarely complained of. The most unendurable symptom was always the itching, particularly when they were getting better. Absolute rest was not insisted upon; and yet the large number mentioned were cured in a relatively short time, although they had mostly lasted months and even years. A flannel bandage was applied and no external treatment used except a simple water dressing, when the burning and itching were excessive, or an oiled rag was laid upon the ulcer.

In conclusion it must be remarked that *carduus* is efficacious in certain forms of rheumatism dependent upon liver diseases. This rheumatism only affects the abdominal muscles. It may extend to the hips or the thighs, at times radiating to the malleoli. The pains may also be felt under the short ribs and in the lumbar region. The liver symptoms already mentioned must, however, be present.—*Zeitschr. des Berliner Verein. Homœop. Aerzte*.

**ACTION OF NAPHTHALINE UPON THE EYE.**—Naphthaline exhibits a most marked affinity for the eye, and is capable of exciting very serious lesions of that organ. Under the influence of toxic doses of this drug there soon develops a serous effusion between the retina and the vitreous; later the effusion appears between the pigmented epithelium of the retina and the conical and striated elements. There is then loosening of the retina which floats between the two liquids. Very soon white unbilicated patches are seen deposited upon the retina, and these are not formed of naphthaline but consist of oxalate, sulphate and carbonate of calcium. Again, in the body of the vitreous are seen floating numerous brilliant bodies; these likewise are not due to deposits of naphthaline. At last the crystalline lens itself is affected, and in space of time ranging from three to thirty days, a soft grayish cataract is formed. Naphthaline then is capable of producing:

1. Detachment of the retina.
2. Papillo-retinal infiltration.
3. Deposits in patches upon the retina.
4. Amblyopia and consecutive amaurosis.
5. Sparkling synchisis.
6. Soft cataract.

Should these effects of the drug lead to a successful employment of the drug in the conditions above named, then will our armamentarium be made richer.—*Transactions of the International Congress of Homœopathy held in Paris*.

**NACRE OR CONCHIOLINE.**—Hahnemann nearly sixty years ago, studied the oyster shell (*calcareo ostrearum*) in bone diseases. Twenty years ago a number of physicians, mostly German allopaths made studies of the pathogenetic action of the nacre or the pearl, and of the effects produced by it on those who worked in it. English, in 1869, Gussenbauer, in 1875, and Jelink, in 1885, successively published their observations. It produces the following: Rheumatoid and osteo-copic pains; osteitis of the extremity of the diaphyses of long bones (never in the middle of the diaphysis or in the epiphyses); osteo-periostitis of the inferior maxilla, sternum, left scapula, radius, right cubitus, left fibula, left femur, left cuboid and left right astragalus. Thus it is seen that nacre acts upon both

sides but preferably upon the left. It has been used successfully in osteomyelitis in young persons, symmetrical periostitis, rebellious hoarseness, ulcerous bronchitis and bronchiectasia.

Klauser has made a chemical analysis of nacre and has found in it two substances: one, calcareous which he named calcoese or siderose, and the other of animal nature which he named combujoline, and which, according to his statements, had much to do with the disease-producing effects of the drug. This shows that it would not be a matter of indifference for one to employ in medicine carbonate of lime made in the laboratory, in preference to that obtained from the oyster shell.

Reasoning from the above, Ozanam was led to employ the fine pearl margarita. This is a disease of the pearl oyster. He found it of use in osteitis, periostitis and bony tumors. Case 1, was that of a farmer aged 47 years. Eighteen months after exposure, he had a painful swelling on the right cheek. An abscess formed near the angle of the jaw, and his attending physician diagnosed an osteo-periostitis of the ascending ramus. After the abscess had opened there remained a chronic swelling and induration of the parts, the skin over which was red and shining. The tumor was hard and interfered with mastication. Six months afterwards, a new complication arose. At every meal during mastication, a limpid water, abundant, flowed from the opening, showing that a salivary fistula had formed. Margarita was finally administered. After six weeks the tumor had diminished two-thirds, the external fistula was almost dry, and the parotid fistula entirely closed.

Ozanam also proposes nacre as a remedy in laryngeal, and pulmonary phthisis—*Transactions of the International Congress of Homœopathy held in Paris.*

**HYDRASTIS IN URETHRITIS.**—Dr. Oscar Hansen reports a case of gonorrhœal urethritis that had been under allopathic treatment with no particular improvement. The discharge was yellowish white and thick, and there was slight burning during micturition. Mercurius sublimatus both locally and internally failed to do much good. Then hydrastis, first centesimal dilution, was prescribed, five drops, three times daily. An injection of hydrastis tincture was also ordered. The patient was entirely cured in three weeks under this treatment.—*Homœopathic World*, October 1, 1890.

**ARSENICUM ALBUM IN SKIN DISEASES.**—A confectioner, aged 31 years, had over his arms an eruption consisting of larger and smaller papules which itch and scale off. The eruption is partly in larger patches, and partly in oval figures; there is also a little of it on the backs of the feet. The skin over the diseased parts is red and raised. The itching is worse at night, and the affected parts burn like fire. Scratching of the eruption makes the itching worse. Arsenicum album 3x was prescribed internally. The parts were washed with lanolin soap morning and evening, and afterwards an ointment of red precipitate was used. In three months the patient was entirely cured.—*Homœopathic World*, Oct., 1890.

**THE TREATMENT OF LARYNGISMUS STRIDULUS.**—In a paper on laryngismus stridulus, Dr. Sheldon Leavitt presented the following indications:

*Calcareo carb.* doubtless occupies the most prominent place, and is especially indicated by the early symptoms, such as late teething, broad fontanelles, perspiration about the head, light stools, curdy movements and restless nights. Should the child be of a scrofulous diathesis, with a tendency to accumulate fat, and yet with the ordinary expression of health, this remedy would be more strongly demanded.

*Silicea* is not so frequently indicated, but sometimes serves us well. Some of the symptoms calling for it are the scrofulous diathesis, pale waxy appearance of the skin, sensitiveness to every impression, a tendency to emaciation, and deficiency of animal heat.

*Arsenicum iodatum* does excellent service when the child is restless and uneasy, has sore mouth, a disposition to looseness of the bowels, skin easily chafed, and the food often vomited.

*Sulphur* will be indicated in weak cachectic children with roughness of the skin.

*Calcareo phosphorica* when there is decided evidence of a deficiency of earthy salts in the osseous system.

*Cuprum gelsenium*, *magnesia phos.*, *nux vomica*, and probably many other remedies may be called for as occasion requires.—*The Clinique*, September 15, 1890.

**TEREBINTHINA IN HÆMATURIA.**—A working man, aged 44 years, had a chancre 24 years ago, which was allopathically treated with sublimate pills. His actual present illness had existed for a year and a half. After micturition there comes blood from the urethra, sometimes but a few drops, and sometimes as much as a teaspoonful. The blood is of a light color and limpid. The urine comes in jets, frequently in the day-time, once or twice at night. No swelling of the prostate. Never any blood with the stools. Nitric acid was first given, but without any benefit. Dark coagulated blood then began to come with the urine. *Terebinthina*, 3d centesimal dilution, was then given. A complete cure was effected in two months.—Dr. Oscar Hansen in the *Homœopathic World*, October 1, 1890.

**A LYCOPODIUM CASE.**—Miss — heard her brother sing a comic song, the chorus of which ran in her head continually afterward; even the pendulum of a clock seemed to be ticking the words. *Lycopodium* was given because it has the symptoms: "A piece of music I once heard came so vividly before the mind that I could almost hear it;" and "In the evening she continues to hear the music she has heard played during the day."—Dr. E. W. Berridge in the *Homœopathic World*, October 1, 1890.

**BELLIS PERENNIS.**—AN ACCIDENTAL PROVING.—A lady, aged 45 years, took a dose of tincture of *bellis perennis* by mistake. It produced marked swelling of the eyelids, and large patches of scarlet flushing over the forehead and cheeks, but without the least feeling of heat or burning. The appearance was like violent erythema, but there was no rash. As the day went on it grew paler, and the next morning there was a peeling off of the skin. The swelling of the eyelids, especially the left, lasted longer than the patchy redness. There was also a peculiar wide-awakeness very early before 3 A.M., and do what she would she could not get to sleep again. This wakefulness was unlike ordinary early morning dozing; she seemed to wake all at once as it were, with every mental faculty clear and on the alert.—*Homœopathic World*, October 1, 1890.

**CHELIDONIUM IN PROLAPSUS ANI.**—*Chelidonium* 2x proved curative in a case with many years' loss of power of retracting the anus after stool; without the aid of the finger prolapsus would continue. It has now been several months since this cure was effected so that it may be regarded as a radical one.—*Homœopathic World*, October 1, 1890.

**RHODODENDRON IN GONORRHOÆAL SEQUELÆ.**—A young married man who had gonorrhœa previous to his marriage complained of drawing pains from the testicles into the abdomen and thighs; there was contusive pains in the testicles; they were painful to the touch, somewhat swollen, and one was rather indurated. The trouble was always worse in wet and stormy weather. Early relief and a cessation of the trouble followed the administration of *rhododendron* 3.—Dr. E. G. Grahn in the *American Homœopathist*, September, 1890.

**SPIGELIA IN CARDIAC SYMPTOMS.**—Dr. E. G. Grahn states that he has, a number of times, used *spigelia* in the third dilution in cases with a loud, almost audible heart beat, followed perhaps by excessive weakness of the heart's beating, and again by violent palpitation. When any of these symptoms existed in persons with functional heart trouble, the action of the remedy was quite certain and prompt.—*American Homœopathist*, September, 1890.

**MAGNESIA PHOS. IN SPLENIC PAINS.**—A lady of middle age had sharp neuralgic pains in the splenic region. A powder of the third was dissolved in water, and teaspoonful doses of the solution administered at short intervals. Relief followed after a few doses.—Dr. E. G. Grahn, *American Homœopathist*, September, 1890.

**CROCUS IN METRORRHAGIA.**—Miss —, aged 35 years, had had for many months a recurring hemorrhage at each menstrual flow. "At the commencement, sensation as if the menses would appear, with colic and pressure towards the genitals. The flowing was increased at the slightest movement. The escaping blood was dark, thick and easily clotted. There was an unnatural pressure in the abdomen." *Crocus* 1x was given in drop doses, every half hour. Rest and proper diet were enjoined. Relief was apparent at once, and the symptoms did not recur in the slightest degree for six months.—*Medical Current*, October, 1890.

**BERBERIS VULGARIS IN NEPHRITIS**—*Berberis vulgaris*, 1x dilution, cured the following case: "Sticking digging, tearing pains in the renal region. The suffering was worse from deep pressure. This disturbance extended down the back, along the course of the ureters into the pelvis. There was also a tensive pain across the small of the back, at the same time the back felt stiff and numb. There was also a peculiar feeling of bubbling under the skin.—*Medical Current*, October, 1890.

**BERBERIS IN CYSTITIS**.—*Berberis vulgaris* cured the following case: Mrs. X., aged 28 years, after a severe lying-in period presented the following symptoms: "Cutting pain in the bladder extending down the urethra. After micturition there was severe burning pain. The urine was yellow, turbid and flocculent. After standing a short time, it threw down a whitish sediment, which later became red and mealy. The pains were tearing. The face was sunken and worn looking. The prostration was great."—*Medical Current*, October 1890,

**SPIGELIA IN NEURALGIA**.—*Spigelia* 3x cured the following case: Mrs. D., aged 40 years, while in good health was attacked by the following symptoms: "The neuralgia began in the occiput, and settled over the left eye and cheek. The character of the pain was tearing, jerking and burning. The suffering was increased by noise, warmth, cold or any jarring of the body. It would begin in the morning, increase during the day, and subside at night. She was very sensitive to any change of the weather."—*Medical Current*, October, 1890.

**THE TREATMENT OF HAY FEVER**.—*Arsenicum*.—Subacute coryza coming every morning with incessant sneezing; extremely abundant mucous discharge; lachrymation; redness of nose and excoriations of upper lip. The nasal symptoms of arsenicum justify its use in the treatment of hay fever, and clinical experience demonstrates the value of the drug. I usually give the 3x trituration four times per diem.

*Nux vomica* is similar to arsenicum. It produces a coryza with incessant sneezing and a continual discharge of watery mucus. Especially is it indicated when a stoppage of the nose at night is substituted for the coryza. We are sometimes in the habit of alternating it with arsenicum. In such cases I give two doses of arsenicum in the morning and two of nux in the evening.

*Kali chloricum* produces a violent coryza with incessant sneezing and abundant serous discharge. I give it usually in the 6th dilution. Probably a stronger dose would be more efficacious.

*Allium cepa* is useful in cases with the well-known indications.

*Cyclamen* produces fluent coryza with sneezing and diminution of the sense of smell. Roth reported a case of hay fever with abundant watery discharge, very frequent sneezing, blunting of the senses of taste and smell, headache and earache, cured by cyclamen.

*Elaterium*.—The inhalation of the vapors of elaterium determines a violent coryza, associated with numerous sneezings and enormous discharge of watery serous fluid. The dose of this drug should be from 3d to 6th dilutions.

*Sabadilla* produces in health a fluent coryza with sneezing; head painful and face altered. These are the symptoms which induced Bayes to use this drug in hay fever. According to his statements *Subadilla* is a precious remedy in hay fever when the serous discharge is very abundant with violent sneezing, with lachrymation, frontal headache and heat and redness of face and eyes. He used 3x dilution internally and externally by olfaction.

*Chininum Sulphuricum* produces a fluent coryza with an acute course, but its indication in the treatment of hay fever is principally because of its intermittent character. When the attacks of coryza come on every day at fixed hours this drug is indicated.

In this case chininum sulphuricum should be given same as in intermittent fevers, that is, in doses of one gramme for adults, taken in two divided doses, as far as possible from the time of the attacks.

In acute coryza of very violent character with unsupportable pain we have found great benefit by the use of the following external application:

Chlorhydrate of cocaine, . . . . .	0 gr., 20 centigr.
Chloride of sodium, . . . . .	0 gr., 20 centigr.
Aqua distillata, . . . . .	10 grammes.

A few drops in the hollow of the palm to snuff through one or the other nares three or four times per diem.—Dr. P. Jousset in *L'Art Medical*, October, 1890.

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TYPHOID FEVER AS NOTED AND TREATED IN THE HOMŒOPATHIC  
HOSPITAL, MELBOURNE.

BY WILLIAM R. RAY, M.D.

(Honorary Physician to the Melbourne Homœopathic Hospital.)

BEFORE entering into the special subject of my paper, it may perhaps be advisable to explain the reason of typhoid fever being so rife in our city, and also how we are situated. Melbourne, the capital of the colony of Victoria until quite recently, had all its sewage contained in surface drains, which not being flushed with any regularity give off their odors in our hot summer months. The arrangements for the removal of excreta have also been very primitive, being both insanitary and dirty. In addition, some three years ago, Melbourne experienced a sudden epidemic of speculation in land estate, which resulted in land being sold at extremely high prices. Houses of various sizes, styles, stability and value were speedily run up by contractors, irrespective of their position and sanitary arrangements. These houses being occupied, with no special attention to drainage or sewage, became in their turn centres of infection, until typhoid had assumed a well defined type, occurring regularly every year; commencing about November (the beginning of our summer) and lasting on until the end of April or May.

The public mind has, however, been drawn to these defects, and one of the most eminent of the English sanitary engineers, Mr. Mansergh, has just left us after investigating matters for three months, and is to furnish us with a complete scheme for the proper disposal of sewage, which will certainly have its effect on the public health. This

has been clearly shown in a neighboring city (that of Adelaide, the capital of South Australia), where the mortality has been reduced by one-sixth since underground drainage has been established. Our hospital is situated on one of the principal thoroughfares leading from the city, and draws its supplies from Melbourne proper, and its suburbs, which have a population of about 350,000. Until within the past year, there was a large swamp at the back of the hospital, which was certainly not beneficial to the health of our patients, but this has since been filled up.

No case is refused except from want of room, so there can be no picking of suitable cases. Within the past two years several municipalities have made special arrangements with the committee of our hospital to treat their indigent poor who are suffering from typhoid fever, which is significant, as it raises our hospital to the position of one of the public charities, and any public recognition of homœopathy in an English community is a distinct step forward.

Having given a brief explanation of the cause of our trouble in this particular direction, I will endeavor to present to you the special symptoms of the disease as seen here.

*At its inception* the patient feels weak and languid; has no energy; everything is a trouble; head feels confused and heavy; aching in back and lower extremities; limbs feel tremulous; sleep disturbed and restless; tongue coated and white; breath heavy and offensive; pain in the abdomen generally referred to the umbilicus; hearing dull; temperature about 99°–101° F.

*In about a week* the patient gives in and thinks there must be something really the matter and seeks advice. Is then sent to bed and is glad to get there; headache intolerable, mostly occipital; muscular pains increased; temperature varying from 101° to 104° pain in bowels, which are somewhat distended; urine thick and loaded with urates; tongue dry and parched, coated with yellowish or brownish fur; sometimes quite dry and shiny as if scalded; sordes on teeth; delirium sometimes active, or else of a low muttering type; pain in abdomen in the ilio-cæcal region where there is tenderness and gurgling.

I have, you will notice, not mentioned the condition of the bowels; the greater number of cases have marked constipation, diarrhœa being the exception although not infrequent.

As a rule the rose-colored spots are neither noticeable or numerous. There is, of course, the characteristic variation between the morning and evening temperatures. Each year seems to present a

special type of its own. For instance, in 1887, diarrhoea and hæmorrhages were present in the greater number of cases. In 1888 the temperatures were uniformly high, ranging as high as 107.5. In 1889 they were more of a nervous type, the greatest trouble being apparently centred in the brain, and associated with this in a few cases, were very heavy perspirations, the majority of which proved fatal. This year, 1890, has been characterized by the great tendency to pulmonary complications, more particularly pneumonia; there were also a good many cases having severe hæmorrhage. One noticeable fact in connection with the appearance of the influenza epidemic in our midst, was the almost complete disappearance of typhoid, although what relation they bear to one another would be hard to say.

*Treatment.*—(a) medicinal.

(b) dietetic.

(c) adjuvants.

(a) *Medicinal.*—An endeavor is made to individualize each case, but the following medicines with their well-known characteristics have proved their value most from a clinical standpoint. Arsenic. alb., bapt., bry., carbo veg., puls. and rhus tox.

*For the hæmorrhages:* secale, tereb. and hamam.

*For the pulmonary complications:* lycop., chelid. and phos.

And for the different degrees of delirium: bell., stram. and hyosc.

As was mentioned earlier in my paper, each year seems to bring into view a varying type of the disease. For the present year, 1890, was specially marked by the absence of baptisia cases, which in former years, had been of service in aborting the disease.

With regard to potencies used, two members of the staff seldom go above the third decimal, another generally prescribes the 30th, while the fourth claims the privilege of running up or down the scale according to the case which is presented. The resident physician is a high dilutionist, seldom prescribing under the 200th.

(b) *Dietetic.*—The principal food used is milk, of which each patient averages about a pint and a half per diem. There is also another article of food to which I would draw special attention, viz., "Murdock's Liquid Food," which I cannot praise too highly. There are very few cases which are unable to take it, and it has the effect of keeping up the patient's strength during the extreme pyrexia, and shortens the stage of convalescence considerably. The quantity given is a teaspoonful every three or four hours, generally in a little milk.

(c) *Adjuncts*.—Each patient is, on admission, sponged with a weak solution of acetic acid which is continued every three or four hours, excepting when asleep. Cold packs are used if the patient be not too weak, and if so then tepid water is used. If the temperature remains at the same point or nearly so for twenty-four hours, then hot packs are used which generally have the desired effect. The tongue and teeth are cleansed every morning with borax and glycerine. For disinfectants, "Sanitas" is used, being one of the few disinfectants which will not stain the bedding.

*Statistics*.—The number of beds in the hospital is 60, but when there is extreme pressure is raised to 70, to the detriment of the patients, as was experienced in 1889. The total number of cases treated from the inception of the hospital, that is to say for the past five years, is 1159, with 102 deaths, which may be tabulated as follows.

Year.	No. of Patients.	Deaths.	Percentage.
1886	16	2	12.5
1887	145	13	8.96
1888	173	17	9.82
1889	408	42	10.29
1890	417	28	6.71

*Summary*.—The type of disease does not differ much from disease as manifested in other parts—save that constipation is more frequent. Results are due to the great care and attention of our resident medical officer, Dr. Bouton; the good nursing of our trained staff, which consists almost wholly of our own trainees, who have been with us for some time and are like a well-trained battalion.

Medicinal treatment based on the law of similars and that invaluable adjunct in whose favor I cannot write too highly in all exhausting diseases, "Murdock's Liquid Food."

I find I have omitted to make any remarks about stimulants. From experience each of us have gained we find that our patients do better without stimulants, as there is then less fever and delirium, but when there is extreme exhaustion with a flagging heart, alcohol is administered sparingly.



## OSMIC ACID IN EAR CASES.

BY ROBERT T. COOPER, M.D., PHYSICIAN, DISEASES OF EAR, LONDON  
HOMŒOPATHIC HOSPITAL.

CASE 1.—On May 29, 1886, there was brought to me, by his parents, a boy of six years of age, looking very nervous and the reverse of intelligent, with this statement:

A year ago he began, without apparent reason, to get deaf; he has always been more or less stupid, though now increasingly so. Beyond an offensive breath there is nothing further amiss with him. On examination, the left membrane was a good deal retracted anteriorly, the malleus handle standing out prominently. It was not possible to elicit an intelligent reply from him, and so I did not make note of his hearing. I found a certain amount of post-nasal granulation, which was scraped but no real blocking. I ordered acid osmic, 3x, 15 drops to go over a fortnight.

June 18, 1886.—Certainly better in many ways; the breath improved, but is again bad. The post-nares again gently scraped, and calcarea phosphorica, 1st decimal, given instead of osmic acid.

July 9th.—Still very deaf; breath offensive, evidently from some hidden ulcerating spot in the recesses of the nose. Perspires a great deal. Hearing, 20 in. on both sides. (Doubtful for reason stated above.) Ac. osmic in 2d cent., 15 drops to half ounce of water, 5 drops, thrice daily in water, was now given, and on August 30th this report came in: Is much better, but has been laid up with measles; breath is less offensive, and can hear things now which he could not have done previous to the measles. Still given to perspiration. To continue same medicine.

September 21st.—Hearing much improved, but getting languid; cannot walk far; perspires a good deal; breath less offensive; bowels inclined to be more confined than usual. Hearing, R. 60 in., L. 50 in. To continue same medicine, and also to have glycerole of hydrastis, 20 drops to an ounce of water, for application to back of throat once a day.

October 26th.—Very much better in his hearing, but breath very offensive. To continue ac. osmic, but to have 7 drops of euphorb. c. to an ounce of diluted glycerine, for application to throat and nostrils.

December 7th.—Has been having much earache; breath less offensive; perspires less, and on the whole hears much better. Ordered hydrastis, 3d dec. pilules; two pilules thrice daily.

From this date until now (October 9, 1890) I heard nothing of this patient, and am reminded of him only by his father coming to consult me *in consequence of the wonderful cure I had effected on his son four years before, and who had remained perfectly well ever since.*"

My idea at the time was that the osmic acid had acted splendidly, but that probably the occurrence of earache had frightened the parents into seeking other advice, particularly as they lived far away from London. *This*, of course, was not the case.

If anything militates against this evidence of the effect of osmic acid it would be the occurrence of an attack of measles while under treatment; for it is a remarkable fact that the exanthemata are sometimes followed by improvement of hearing in deaf cases, and, of course, it is always well to give science the benefit of doubts.

CASE 2.—A boy of 15 was treated by me some ten years ago at the L. St. Hospital for adenoid growths. Symptoms: deafness with rumbling noises in the ears. History: Two years before, fell down some steps, was brought home speechless. *One year* after this a cold with nasal discharges came on and with it deafness. Speech is thick and nostrils appear blocked; nose, when he blows at it bleeds; occasional otorrhœa from both ears. Osmic acid solution (1-200), given in  $\frac{1}{2}$  drop doses caused discharge to come more profusely than ever from the left ear, and his hearing very distinctly improved.

CASE 3.—Tinnitus, with profound deafness, five or six years in a woman of 56, noise of rushing water night and day, began with noises in head; some obstruction of the nose easily removed by syringing, when she hears better (no visible polypus). Result: The tinnitus went and the deafness decidedly improved under osmic acid (1-200), as above.

CASE 4.—Girl of 14. Diagnosis: Adenoid growths. Ac. osmic, 3d dec., improved her hearing very much, but was seized with exhaustion while taking it; this went away with ac. hydrocyanic, 3d dec.

CASE 5.—Otorrhœa, double, perforations large in both; very much irritation in the ears. Great benefit to discharge and hearing from acid osmic, 3d dec., 2 drops to 6 oz. water; teaspoonful thrice daily.

CASE 6.—James Down, æt. 36, admitted to hospital July 31, 1886. Deaf some two years; pains in both ears when takes cold, with sneezing, catarrh and sore throat. Pasty post-nares. Acid osmic, 2d dec., as last. Hearing 30 in. on right, and 20 in. on left.

August 28, 1886.—Very much more sneezing and grayish mucus keeps running from the nose. There is a great deal of irritation in the ears and nostrils. Uses up a pocket-handkerchief in half an hour. *Hearing quite normal.* To go without medicine.

His next attendance was three years after (April 13, 1889), when he reported himself as having remained well till the previous October (1888). He is now having continual discharge from the right ear with offensive odor, much cold feeling and numbness of the right ear only. The right meatus looks red and swollen,

and there is much middle ear ulceration. I order osmic acid, 6th dec., pil. j. thrice daily for a month.

May 18th.—For first two weeks was much better, but the last fortnight not so well. Ordered acid carbol., 30, but without any change; and then on June 1, 1889, I put him on acid osmic, 1st cent.; 7 drops to 6 oz. of water; 3j. t. d.

June 15th. Much better as to ears, discharge thinner. A great deal of discharge from the nose with sneezing; thin stringy discharge; "*not so well in himself with this medicine.*" To continue it.

June 30, 1890. Discharge very much better and feeling better, had much discharge of stringy secretion from the nostrils, the left especially last week, and a good deal of sneezing, but is now much better.

Hearing normal, right ear nearly healed. To continue medicine for a fortnight but to cease attending.

CASE 7.—Mary A. V. æt. 15 had otorrhœa during childhood; deaf in both ears, coming gradually for some months; tinnitus with perforations in both; dreams a great deal at night; bowels confined; monthlies, one year, regular. Acid osmic, 6, 2 drops to 6 oz. of water: 3j. x. d. After 1st fortnight, dreams less, bowels regular, feels much improved. Same for two weeks, and then nothing.

June 19, 1886. Very much better; the tinnitus and hearing were very much better the fortnight of medicine, and returned when without it. Sleep more peaceful, bowels regular. Continued.

July 17, 1886. In every way well.

These cases are interesting as they lead us to suppose that we have in osmic acid a more than usually active curative in chronic otorrhœa when combined with very severe aural, nasal and post-nasal irritation.

My reason for employing it in the first instance arose from the irritating effect the fumes of osmic acid exerted upon the nasal mucous membrane of a patient whose daily occupation brought him into contact with them.

My employment of it, though extending over a period of ten years has not been extensive, the above cases being almost the only ones in which I have prescribed it.

## ARE VALVULAR DISEASES OF THE HEART CURABLE?

BY E. M. HALE, M.D., CHICAGO.

(Read before the Southern Homœopathic Association, at Birmingham, Alabama, November 10, 1890.)

THIS question has never been satisfactorily answered, nor do I presume to answer it. The therapeutics of cardiac diseases has not yet reached that stage at which we are warranted in giving a definite answer.

All valvular diseases, except the traumatic, begin with an endocarditis. This endocarditis is either rheumatic or a secondary effect of disease of the kidneys. It may be caused by certain drugs.

If we are to seek a curative medicament for valvular diseases, we must find one or more, which are capable, when administered to the healthy man or animal, of producing acute endocarditis.

Not only must they be capable of causing the acute stage, but they must be the cause of the remote results.

The records of autopsies in fatal cases of poisoning are meagre in this respect. Fatal results from acute poisoning usually come on so soon after the ingestion of the drug, that it has not had time to produce valvular lesions. To give you a graphic picture of what a drug may do, I will quote the classical experiment of Robertson, who, by injecting lactic acid into the peritonæum of an animal caused the following pathological changes in the valves of the heart:

“Richardson states that when the animals experimented upon by him were examined within a period of ten hours after the introduction of a solution of lactic acid into the peritonæum, the tricuspid valve was found to be highly vascular and villous, to have lost its ordinary polish and transparency, and to have exhibited minute droplets of lymph upon the free margin. Examined at a somewhat later period, the segments were tumid and inadequate to close the orifice, and yielded an opaque and viscid exudation on being punctured.

“At a still more advanced period they were dense and thickened, but less swollen, and exhibited beneath the surface a layer of solid fibrin, and masses of the same material were deposited upon the edges.

“Finally, they were found to have shrunk and become inadequate by retraction of their edges. With regard to the genesis of the tissue changes which characterize the several stages of acute val-

vular inflammation, the first is distinguished by congestion of the *vasa vasorum*, proliferation of the connective tissue corpuscles and consequent thickening and opacity of the valve curtains.

"The second stage consists in efflorescence, or outgrowth on one of the lamellæ, by accumulation of corpuscular elements which are liable to undergo granular metamorphosis and subsequent disintegration and detachment under the action of the blood-current. Hence, so-called ulceration of the valve, if one lamella only be involved, or perforation, if both lamellæ are eroded."

This is a very good picture of acute endocarditis with valvulitis.

Now, if we had the record of poisonous effects of medicines which were closely similar to the above pathological changes, we should be able to cure the acute diseases with such remedies.

If lactic acid, when taken into the stomach, would cause all the above symptoms, it would be the specific remedy for the disease. But in the above instance the acid was "injected into the peritonæum," which means, I suppose, into the peritoneal cavity.

The question arises—what was the real agent which caused the inflammation of the valves? The lactic acid may have been changed into some other poisonous product. It was once the theory—and is now held by many—that the presence of lactic acid in the blood is the prime cause of rheumatism.

But this assertion has not been fully proved. When injected into the peritonæum it should, according to that theory, not only cause valvulitis, but synovitis and other rheumatic inflammations.

Some of our homœopathic physicians have lately reported cases of valvular disease treated with apparent success with attenuated lactic acid, but I doubt the trustworthiness of such reports.

The main remedies for acute endocarditis and valvulitis are:

I. Aconite, verat. vir., cactus, kalmia and salicylate of sodium. These act not by virtue of any power they possess to cause the disease, but by restraining the action of the heart and lowering the temperature.

II. Arsenic, belladonna, bryonia, spigelia, are next in importance, because they *have* the power of causing similar lesions of the valves and endocardium.

One of Class I. should always be used in connection with Class II., as they are indicated by the symptoms.

These remedies should be aided by the free use of alkaline beverages, and alkaline saline laxatives, to keep the intestinal canal empty of poisonous substances. When the acute inflammation has

subsided we have the results in the shape of thickening, or vegetations on the valves. To remove these the most useful remedies are the iodides, principally the iodides of arsenic, ammonia, baryta, potassium, lithium, gold and silver, and the pure iodine itself.

These should be used in the attenuations, from the 1x to the 6x. I believe a careful and persistent use of these agents will enable us to restore the integrity of the valves in a large proportion of cases. All valvular structural changes may be put in two classes:

I. *Obstructive*, causing narrowing or stenosis; and

II. *Insufficiency*, or widening of the orifice.

The results of both conditions are much the same. If the valves from swelling or vegetations cause obstruction the chamber behind the narrowed valve will *dilate*. The muscular structure of the walls of the chamber, in order to force the blood through the narrowed orifice, must exert unnatural force, which results in *strain*, and this strain tends to weaken the muscular fibres.

This in time causes *thinning* of the muscle, and we get dilatation. In Class II. we have the strain, the thinning and dilatation, not from the *vis a tergo* direct, but from the regurgitation of blood through the too open orifice, distending the chamber behind the diseased valve.

Unless arrested this thinning may go on to extreme thinning and dilatation until the muscular power is extinct, and cardiac paralysis puts an end to life. But nature, even if unaided by remedial agents, often prevents such a fatal ending by a process which we call *compensation*.

This is a restoration of the muscular fibre, such as we see in muscular atrophy from strain or weakness, under the influence of massage or the faradic current.

When we discover that the heart-walls are failing, and dilatation impends, we must aid nature by the use of those agents which tend to restore the integrity of muscular tissue.

Nutritious foods, pure air and proper exercise should be aided by such strictly homœopathic remedies as aconite, veratrum viride, veratrum album, and gelsemium, in the 3x to 6x dilutions; or the purely cardiac tonics, such as digitalis, strophanthus, convallaria, anaholium, nux vomica, ignatia or strychnine, in appreciable doses, until the muscular structure of the walls of the heart's cavities have attained their normal strength.

When this end has been reached an equilibrium will be estab-

lished, in which the muscular structure is strong enough to oppose the obstruction or insufficiency of the valves.

This condition is called *complete compensation*. In this condition the valvular trouble is powerless to injure the important organs of the body. The circulation will become quite normal, and the patient live comfortably many years.

We may not have cured the valvular disease, but we have rendered it powerless to destroy life.

This is probably as near as we can ever arrive at the real cure of structural valvular changes.

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## EFFECT ON THE NURSING CHILD OF OPIUM TAKEN BY THE MOTHER.

BY H. D. CHAKRAVARTI, M.D., SERAMPUR, BENGAL.

ONE of the gleanings in THE HAHNEMANNIAN of April last (page 260), reminds me of a case which fully illustrates the effect of opium through the mother on the nursing child. Recently, I was one day summoned to see at once the son of —, who was reported to be lying at the verge of death. The child, who was then about four weeks old, was lying stupefied on his mother's lap with a cyanotic face and half-open eyes. His abdomen was slightly distended, mouth open, forehead and axillæ covered with sticky sweat, pupils rather contracted and pulsations of the radial artery full and slow. I also learned that the present symptoms developed gradually since the early morning, and they were not accompanied by screaming, restlessness, tossing of the head, etc. All these symptoms presented such a striking similitum to the effects of opium, that I at once declared it to be a case of opium poisoning; and the father, being a habitual opium eater, I did not hesitate to ask if opium had been administered to the child in order to check the attack of dysentery from which he was said to have been suffering for the last eight or nine days. The mother replied that no opium was ever given to the child; but that she herself had been taking it regularly in about the size of a rye-seed for the cure of dysentery, from which she also had been suffering. It is needless to mention that a few drops of belladonna brought the child out of the condition described above. From this case it is evident that opium may also be classed as a cumulative poison; for otherwise it

would have certainly produced its toxic effects some time previously, as the mother had been taking it long before the child was seized with the narcosis of opium. But one thing very remarkable is, that children whose mothers are habituated to the use of opium long before their conception, never seem to suffer from any ill-effects of the narcotic; perhaps because their tender systems become so well accustomed to its action from the period of uterine gestation.

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### SAND-BUR (PORCELAIN) IN THE LARYNX.

BY F. E. WILLIAMS, M.D., HADDONFIELD, N. J.

THE following case is reported as being unique as to the nature of the foreign body:

On the 28th of August, 1887, Harriet R—, while running through an orchard, caught a sand-bur on her finger; in her hurry she took it between her lips and pulled it off, intending to blow it away; before doing so, however, she took a deep inspiration in order to have sufficient breath to dislodge the bur; as a result it was carried with the inhaled air into the larynx.

Violent paroxysms of coughing and strangling followed, and all ordinary means, such as lowering the head and pounding on the back, were resorted to in vain.

The little girl was brought to my office, a distance of five miles, about an hour after the accident. She did not seem very nervous over the affair, but the pulse was slightly accelerated and there was some fever, accompanied by a constant hacking cough and quantities of frothy expectoration. The latter was thoroughly examined, but no trace of the sand-bur could be found. There was complete aphonia; deglutition produced a sticking sensation in the larynx, and pressure over the trachea provoked cough and pricking pain.

An examination of the throat with the aid of a tongue-depressor showed nothing but a generally inflamed mucous membrane; thinking that if she were kept quiet in the recumbent position the bur would be dislodged, she was given aconite and ordered to bed. She passed a fairly comfortable night, slept considerably, but would have attacks of cough by which she was aroused, but would soon fall asleep again.

The following morning she was bright and cheerful, still expecto-



rating freely and complaining of a sticking in the trachea; pharynx more inflamed. She was ordered to remain in bed, and belladonna and mercurius viv. were given in alternation. Under their influence the pharyngeal inflammation subsided; the aphonia continued, she being able to speak only in a hoarse whisper. There was little change until the morning of the 31st, three days after the accident, when I found the patient and family discouraged, owing to the non-appearance of the bur, which had evidently become so firmly imbedded in the mucous membrane that it would only be dislodged when ulceration and sloughing had taken place, which must be avoided if possible. On this account I requested a consultation with a specialist on diseases of the throat. This was readily consented to, and, at my suggestion, Dr. Horace F. Ivins, of Philadelphia, made a laryngoscopic examination. He found the bur deeply imbedded in the anterior commissure of the larynx below the epiglottis; some of the bur projected almost against the cushion of this valve; the greater part, however, was wedged between the anterior ends of the ventricular bands above and the vocal bands below. The anterior third of the glottic space was encroached upon, and the bands were mechanically prevented from approximating. The obstructing body was so covered with a glairy mucus that it was impossible to tell its exact nature. The laryngeal mucous membrane was but slightly congested; the epiglottis was normal, and there existed no evidence of a serious infiltration at any point.

The projection upwards accounted for the pain during deglutition, the epiglottis cushion pressing upon the bur; the impaction of the latter between the vocal bands explained the loss of voice; and the absence of dyspnœa was due to the position of the bur and lack of œdema.

The larynx was well painted with a four per cent. solution of cocaine. The foreign body was then grasped with a pair of Schrøtter's modified tube forceps, and little pieces torn off; it was, however, impossible to remove the whole mass without danger of lacerating the tissues, thus setting up severe inflammation, with, perhaps, destruction of tissue and a resultant œdema. For this reason the bur was crushed as completely as possible, with the hope that it would be expelled piecemeal. As no œdema was present, and no decided inflammation had appeared, it was hoped that suppuration would not occur, although necessary arrangements were made for scarification, intubation or tracheotomy, should dyspnœa supervene.

On the night of September 1st and during the following Monday

(four days after the accident) several shreds of woody fibres were expectorated, showing that the bur was breaking down. From this time little change in the condition of the patient was noted until the 7th of September; when two "plugs" of mucus were expectorated, in which was considerable woody fibre. The voice improved at once, although quite hoarse and weak. On the night of September 11th (fourteen days from the time the bur lodged in the throat), while sleeping, the patient was aroused by something coming into her throat which seemed quite large; its dislodgement was accompanied by a tearing sensation in the larynx. She did not sufficiently awaken to realize what had happened until after the mass had been swallowed. It was evidently the remainder of the bur, surrounded by thick mucus, for in the morning her voice had greatly improved, and continued to grow better until very nearly restored to its original condition, when she was discharged, September 17th. Since then she has experienced no bad results whatever, and, with the exception of a slight huskiness in the upper tones, her voice is as good as ever.

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REMARKS ON THE DIAGNOSIS OF ABSCESS OF THE BRAIN, WITH SPECIAL REFERENCE TO THE QUESTION OF TREATMENT.

BY CLARENCE BARTLETT, M.D., PHILADELPHIA, PA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,  
September 17, 1890.)

IN 1886, Dr. J. Orne Green, an eminent old-school authority on diseases of the ear, writing concerning the treatment of abscesses of the brain following aural diseases, said :

"The result of abscess of the brain is invariably fatal. Of treatment nothing can be said."

These few words about represented the opinion of the great majority of the profession at that time. The great obstacle to successful treatment was the inability on the part of the physician to diagnose the presence and the position of the abscess, and the fear of the surgeon to explore the sacred cavity of the cranium. In 1888, Dr. Roswell Park, of Buffalo, in a paper read before the Congress of American Physicians at Washington, on "The Surgery of the Brain as Based on the Principles of Cerebral Localization," presented a general review of what had been accomplished in the realm of cere-

bral surgery: Sixty-seven cases of operation on the brain were reported in abstract; of these, fifteen were cases of abscess of the brain, eight of which recovered, and seven died. While the percentage of recoveries is not as large as we would like, still it is sufficiently great to show that the surgical treatment of cerebral abscesses has a future before it. Without operative interference, all of these cases would have certainly died.

Since Park's paper appeared, numerous other cases have been reported, the mortality among which has been large. In most of them the operation was postponed until destructive changes had progressed so far as to preclude all possibility of a recovery. This was so in the case reported by me in the *HAHNEMANNIAN MONTHLY*, for May, 1890. From the character of the wall of the abscess, it was plain that the disease had existed several months at least. The large area of softened brain-tissue surrounding the encapsuled abscess made the case a hopeless one.

The main difficulty, therefore, in the treatment of brain abscesses, has been, and is yet, one of diagnosis. Given a positive diagnosis that an abscess exists in a certain locality of the brain, and the indications become clear. Unfortunately, positive data are not always available. While in the majority of cases it is possible to recognize the existence of the abscess, still the diagnosis is generally based on what would in the courts be called circumstantial evidence, aided by a process of exclusion.

The object of the present paper is to present as briefly as possible a review of the data on which a diagnosis of cerebral abscess is to be made, together with such as have a bearing on the question of treatment.

In the examination of suspected cases no circumstance, however apparently trivial, should be neglected. The onset of the disease is generally insidious, especially so in those cases following suppurative disease of the middle ear. In fact, the more insidious the advent of the trouble, the more likely it is to be a case of abscess, and the less likely to be one of the other intracranial complications of aural disease, meningitis and sinus thrombosis, for example.

First and foremost, the etiology of abscesses of the brain must be borne in mind. At the present day, it is generally conceded that idiopathic abscess of the brain is an impossibility. All cases of cerebral suppuration must result from one of the following causes:

1. Traumatism.
2. Middle ear suppuration.

## 3. Tuberculosis.

## 4. Metastasis.

Tubercular abscesses are almost certainly beyond the aid of surgical skill, so that their recognition becomes a matter of but little practical moment. The entire removal of the cheesy infiltration of the brain is impossible, and the portions remaining after the operation would only renew the suppurative process. More than this, tubercular processes of the brain are almost invariably associated with extensive tubercular changes in other organs, especially the lungs. Metastatic abscesses afford but little opportunity for help, for they are rarely single. Like the tubercular, they are associated with extensive pathological changes in other and important organs. Cases arising from traumatism and aural disease are the only ones that can be reached by surgical treatment. Fortunately, these constitute fully nine-tenths of all cases. It is to them, that my remarks are intended to apply.

The history of a previous injury in an obscure case of brain trouble becomes then a very important matter. It apparently makes no difference whether the traumatism be severe or light; abscesses have followed the most trifling and the most severe. Von Bergmann insists upon but one universal characteristic of these injuries, namely, that the external integument be broken. It is not necessary that the cranial bones be fractured, or their fibrous covering injured. The solution of continuity of the integument is the only prerequisite. Pitt, on the other hand, makes an injury to the bones themselves, the *sine qua non*, and thinks that slight injuries have but little influence. Sight must not be lost of the fact that Pitt bases his observations on cases seen in Guy's Hospital, all of which were brought in suffering from severe injuries, and in whom the abscess developed almost immediately on the reception of the traumatism. Even though the brain substance be severely contused, no abscess will result, according to von Bergmann, if the integrity of the external integument be preserved. The time after the receipt of the injury at which the abscess takes place varies greatly in individual cases. Abscess never appears under two weeks after the accident. This is an important point as it serves to differentiate abscess from meningitis and encephalitis, two affections presenting a confusingly similar symptomatology to abscess, but both of which come on immediately after the exciting cause. All cases of cerebral abscess do not follow so closely on the reception of the injury. Damer Harrison has reported a case in which the abscess was not recog-

nized until eleven years after the blow that gave rise to it. The usual interval, between the injury and the appearance of cerebral symptoms, in case the latter do not come on within a few weeks, is from three months to a year.

Ear disease, it is now generally conceded, is responsible for nearly one-half of all cases of cerebral abscess. The portion of the auditory apparatus, disease of which causes brain complications, is the middle ear, and never the internal. It is worthy of note that middle ear suppuration very seldom causes brain abscess until it has existed for a long time, for months at least, and generally for years. Park says that acute suppurative otitis media never occasions cerebral abscess; but Bergmann in his valuable monograph quotes one such case, which proves the possibility of the occurrence. Brain complications supervening on acute otitis media are almost invariably cases of meningitis or sinus thrombosis.

In some cases traumatism seems to combine with the aural suppuration to excite brain abscess. Thus, the latter has been known to occur shortly after the receipt of a severe box on the ear, or even after the operation of opening the mastoid cells. In this connection I must express my opinion concerning the methods of performing the operation. Chiselling cannot but jar the entire head; the concussion thus produced, may increase existing cerebral inflammation, or start an inflammation that had not already existed. The mastoid trephine, on the other hand, opens the cells without any shock whatever.

The importance of these two factors in the ætiology of brain abscess, traumatism and suppurative otitis media, must be ever borne in mind, for the symptomatology of the disease is such as to give us but little light in their absence. These symptoms may be classed under the following heads:

1. Symptoms due to the suppuration itself.
2. Symptoms resulting from the increased intracranial pressure.
3. Symptoms resulting from the destruction of certain structures in the brain, and varying with the locality of the lesion. These are the so-called area symptoms, or localizing symptoms.

Among symptoms of the first group may be mentioned increase of temperature. This point is insisted upon very strongly by von Bergmann, while Nancrede and others affirm that in cerebral abscess, the temperature is almost always sub-normal. Pitt says that pyrexia is rare in uncomplicated cases, and that when the temperature is high, and the initial rigor marked, thrombosis of some of the

cerebral sinuses has taken place. Sir Wm. Stokes likewise regards a perfect apyrexia as consistent with the presence of a cerebral abscess. Bergmann contends furthermore that in some cases, at least, the temperature on the affected side is greater than that of its fellow. He cites a case in point in which the difference between the two sides was  $1.8^{\circ}$  F. The value of the thermometer in the diagnosis of cerebral abscess thus becomes a question of dispute. Each observer has in all probability had the misfortune to see but few cases of this disease, and their observations must of course have a limited value. Cases of uncomplicated abscess have been reported in which the temperature fluctuated from  $103.5^{\circ}$  F. to below normal.

Admitting fever to be a not infrequent symptom of cerebral abscess, its value is somewhat lessened in cases following aural disease, for we must first assure ourselves that it has not arisen from extension of the inflammation to the mastoid cells. In all cases in which an accession of fever points to brain disease, and surgical procedures seem indicated, the exploratory trephining of the cranium should be preceded by the opening of the mastoid. The latter being found healthy, other sources of inflammation must be sought.

The pulse is usually frequent. It only becomes slow in advanced cases when the abscess is large, and intracranial pressure correspondingly great.

The symptoms arising from the increased intracranial pressure are essentially the same as those present in cases of brain tumor. They are, however, characterized by their insidious onset. In fact, the more insidious the mode of onset, the more likely are the symptoms to be due to abscess as compared with meningitis and thrombosis. They may exist for months and years, without giving rise to a suspicion as to their real nature. Prominent among the pressure symptoms stands headache. This is apt to be not as severe as in the case of tumor. It is variable in its intensity. Its most important modality is its tendency to exacerbation with the rise in temperature, at which time the pulse rate may fall. Pitt makes the peculiar observation that the headache accompanying abscesses from disease of the middle ear is apt to be more severe than that in the case of abscesses coming on from other causes. The explanation of this is to be found in the fact that abscesses consecutive to otitis media are usually large, and the intracranial pressure is correspondingly great. As in the case of brain tumor, the pain may occupy almost any relation to the seat of disease, though usually near the lesion. Other pressure symptoms are drowsiness, unconscious-

ness, coma, Cheyne-Stokes respiration, and slow pulse. All of these may come on to a marked degree and then disappear almost entirely, thus deluding physicians into the hope that recovery is about to ensue, and that the diagnosis of brain abscess was a mistake.

Optic neuritis which is so frequent a symptom of brain tumor is rarely found in uncomplicated cases of cerebral abscess. Pitt notes its presence in but two of the uncomplicated cases of his series; while he found it almost invariably present in cases of sinus thrombosis. He therefore draws the conclusion that optic neuritis does not favor a diagnosis of abscess. When present as an accompaniment of intracranial suppuration, it is never as severe as in tumor. It may even be limited to but one side, that on which the abscess exists.

The symptoms arising from the special location of the abscess in the brain are of but comparatively little value, except in those cases in which the symptoms point to disease of the motor areas. Abscesses in the frontal, temporo-sphenoidal, and occipital lobes, rarely give rise to area symptoms. The special symptom supposed to accompany disease in the occipital lobe, is hemianopsia, and yet in but one instance of abscess in this location, has this disturbance of vision been noted, in the case reported by Janeway. The infrequency with which abscesses give rise to area symptoms is to be accounted for by the fact that the suppurative process is of slow growth; the consistence of the abscess is such as to make an equable pressure in all directions; its substance being soft, the pressure exerted is not so injurious as it might otherwise be; and lastly the abscess is usually situated in the white substance of the brain, a portion less important from a physiological standpoint than the gray matter.

Were we to rely then upon the localizing symptoms we would fail very frequently in diagnosis. Fortunately, a study of the ætiological factors at work in each case is of value in this connection. Toynbee laid down the rule that disease of the middle ear was liable to be followed by abscess in the temporo-sphenoidal lobe; while in cases in which the mastoid process is involved, the intracranial suppuration will be found in the cerebellum. This law is not infallible. It is simply a statement of the usual sequence of events. McBride and Miller make the further observation that when the auditory nerve is involved, the suppuration is probably beneath the tentorium. When the auditory nerve is not affected, the abscess is probably in the temporo-sphenoidal lobe.

Experience teaches that nearly nine-tenths of all cases of cerebral abscess consecutive to aural disease attack the temporo-sphenoidal lobe. Of seven cases observed by Barr six were thus located, while the seventh was beneath the dura mater in this locality. This author makes the estimate that 75 per cent. of all cases of abscess following aural suppuration are to be found in the temporo-sphenoidal lobe. All of these can be reached by a trephine opening made at a point one inch and a quarter behind and one inch and a quarter above the external auditory meatus. And this I think should be the seat of operation in every case unless localizing symptoms call positively for some other point of attack. In the majority of cases of abscess of the temporo-sphenoidal lobe area symptoms are absent, as above stated. A large portion of its structure may be destroyed without interfering with a single cerebral function. An exploratory operation in suspected cases can then do no harm. In cases in which the localization is in doubt, this portion of the brain may be explored first, as it stands operative interference better than any other portion. The increased intracranial pressure produced by the abscess exerts its influence on distant parts, so that we may expect the corresponding hemisphere to give evidence of impaired function. In my case, to which reference has already been made, the existence of hemiplegia was wrongly taken to indicate an abscess high up, pressing on the motor areas. The autopsy showed that the abscess was in the temporo-sphenoidal lobe, and that the pressure came from below. I think, therefore, that in view of the frequency of involvement of these lobes, one is justified in ignoring area symptoms when they are of an indefinite character, and making an exploratory operation in this region. In some cases local tenderness is a valuable guide. It is especially apt to be present when the dura mater is inflamed.

Abscess of the cerebellum is not very frequently attended with area symptoms. The localization of the lesion in this position must be made by a process of exclusion. The suppuration usually involves only a lateral lobe, disease of which is at present regarded as being incapable of giving rise to a definite symptomatology.

As for traumatic abscesses, area symptoms have not, so far as I am aware, aided in the localization of the affection in a single case, aside from those in which the speech centres or the motor areas have been involved. Many abscesses arising from traumatism have been operated successfully, but the surgeon's guide in nearly all has been the scar, or some such local sign. While the cicatrix may, in many instances, be a good guide, it is not infallible, as the abscess may have



originated from contre coup, and may, therefore, be found in a portion of the brain far removed from the seat of injury. As in the case of other abscesses, the onset is insidious. In early cases the only sign oftentimes consists of peculiar behavior of the wound, which suppurates more than usual, or if there be a compound fracture, there is escape of pus from beneath the fragments. The early abscesses are generally superficial, while those coming on late are almost invariably located in the deeper structures of the brain. The latter it is certain are not the result of bruising of the brain substance, for should that organ sustain a bruising so severe as to extend thus deeply it is almost certain that death would soon follow. In all cases it is a significant fact that long-continued suppuration of the external wound favors the abscess formation. This is a practical point by way of prophylaxis, as it impresses one with the importance of rigid antiseptic measures in the treatment of all scalp and head injuries.

In the case of brain symptoms coming on during the course of aural disease one must not lose sight of the fact that vertigo, high fever, clouded intellect, and even convulsions and delirium, may all accompany otitis media acuta, and yet these serious symptoms may all disappear promptly after incising the membrana tympani and giving vent to the confined secretions. The symptoms in such cases are the result of increased intra-labyrinthine pressure.

In closing, I cannot avoid impressing upon my audience the importance of resort to operative measures in every case of cerebral abscess. Untreated, they all end in death. Prompt action, on the other hand, saves a goodly number of cases. The cases of this character observed by each physician are few in number. Rarely does a practitioner see but one such in all his experience. Many escape them altogether. Few as these cases may be in individual experiences they are in the aggregate great. It is estimated that nearly one hundred people die annually in London alone from brain affections consecutive to aural disease. What the exact number is in the large cities the world over I do not know; but I am satisfied that it is by no means small. In light of the almost certain death under any other course, I feel that no case should be allowed to die without some effort to save him by operation.

## PATHOLOGY OF UTERINE GROWTHS.

BY DEWITT G. WILCOX M.D., BUFFALO, N. Y.

(Read Before the Homœopathic Medical Society of the State of New York.)

It is beyond the scope of this paper to describe the minute analogy and histological character of uterine tumors, but instead to detail such features as may aid us in recognizing their relation to the uterus and their peculiar conduct under varying conditions. A great deal has been written relative to the classification of uterine growths; thus we have the sub-mucous, the polypoid, the fibrous polypus, the interstitial, or intermucal, and the sub-serous, the sub-peritoneal or the pedunculated. In all these are simply the same kind of tumor in various stages of development. It would seem to be a mistake to so classify them. Properly speaking they should be classified according to their construction, and therefore we will speak of them as the soft cedematous myoma and the nodular myoma.

First, as to the name these non-malignant growths should receive. For a long period they have been designated as fibroid tumors, but recent investigation has demonstrated that very few of them possess simply fibrous or connective tissue, but the large proportion contain both muscular and connective tissue, and are therefore truly fibromyomata. Tait is very emphatic in saying that the term fibroid is altogether erroneous and should be dropped because the muscular fibres play so important a part in their construction. I am quite confident that originally all of the myomata are found in the walls of the uterus, and are therefore interstitial, and the polypoid, sub-mucous and sub-peritoneal varieties have become such through a process I shall describe. Let us consider a so called polypoid myoma.

This has become so by a gradual process of enucleation and has been forced into the uterine cavity with a covering of more or less uterine tissue, besides the mucous membrane. In order that this process of enucleation may take place the tumor must be of relatively small size and it must be in close proximity to the mucous surface. There is no doubt but that the vast majority of myomatous polypi originate in sites where there is a distinct layer of uterine tissue between them and the mucous membrane, for such a layer can be traced over them from the pedicle.

Let us imagine we can look into the uterine wall and watch the

process, enucleation. Here we see a small myoma situated in the muscular tissue (see Fig. 1.).

The constant contraction of the uterus which its presence excites and which is increased at each menstrual flow, tends to push it further and further toward the uterine cavity (see Fig. 2.). Soon a

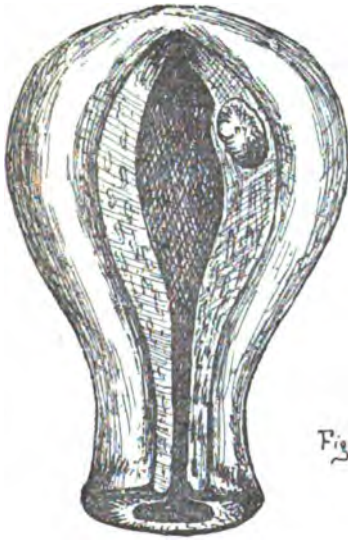


Fig 1



Fig. 2.

portion is pushed loose and only a stout pedicle joins it to its old seat (see Figs. 3. and 4.). The contraction now becomes more pronounced

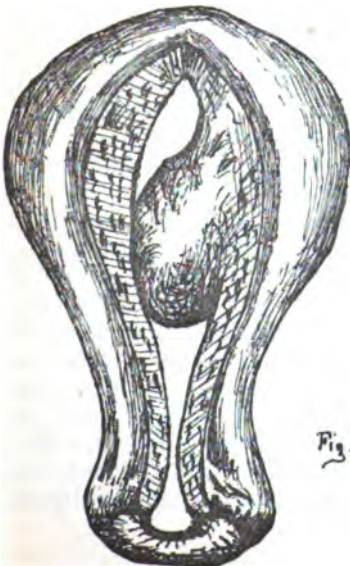


Fig 3.

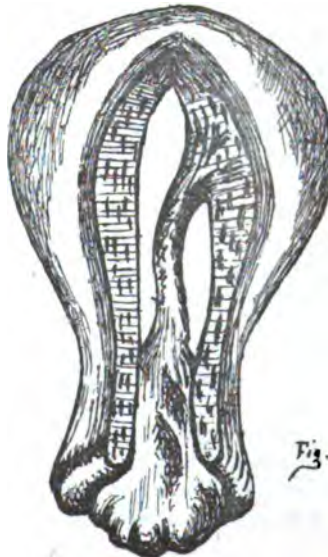


Fig. 4.

because there is a decided substance in the cavity for it to act upon. The pedicle is stretched and at the same time it becomes atrophied. In time it is pushed into the cervical canal from which it must soon extrude from the os, waiting only to have the pedicle severed when it can be removed.

When this enucleated polypoid growth reaches the cervix, a condition similar to labor begins, and expulsive pains, severe in proportion to the size of the growth, take place. The agony caused by the birth of some of these tumors is quite equal to that of child-birth.

There is sometimes excessive hæmorrhage, and patients not infrequently die at such crises. It must be remembered that a patient having expelled such a tumor requires the necessary time for involution as she would in child-birth.

I shall not take up the surgical treatment of these growths, while yet they are undergoing the process of enucleation, but will leave that for the discussion. In dismissing the subject of polypoid myoma, I want to call attention to the fact that all polypoid growths were originally interstitial, and that the so-called sub-mucous tumors are only a stage in the process of enucleation. But I would not be understood as saying that all interstitial tumors become polypoid.

About three months ago a young girl came to my office in a very anxious mood, complaining that she had not been unwell for two months—indeed, it seemed she had some cause for anxiety, for the elicited symptoms were nausea, a sensation of weight in the pelvis, and a frequency of urination.

A hint as to the possible cause of her difficulties brought forth a stout denial, in which she seemed so earnest and honest I was fain to believe her in spite of the seeming strong evidence. Relying upon the developments of time to aid in the diagnosis, I dismissed her with a little medicine and an injunction to report soon. In a week she returned, sadder than ever that the long looked-for flow had not appeared. Some direct interrogation obliged me to still regard the girl honest, and believe the symptoms were not due to pregnancy. She then gave her consent to a digital examination. I found the cervix considerably obliterated, the body of the uterus enlarged uniformly, and the os dilated to admit the index-finger. There was nothing protruding from the os, indeed nothing seemed to counter-indicate a natural pregnancy of about four months. At her next visit (having become convinced of her truthfulness), I passed the sound cautiously into the cervical canal. It passed easily, deviating to one side on reaching the uterine cavity, passing onward to the fundus, showed an elongation of the organ, and on one side came in contact with a hard resisting body which could be partially out-

lined with the sound. Having ruled out pregnancy, the first thought which came was, is it a polypus? Certainly not a mucous polypus, as they seldom, if ever, reach such a size, do not cause the uterus to enlarge, or dilate the cervix. It might have been an interstitial fibroid some time ago, but had now pushed so far into the uterine cavity as to have passed that stage. As to its being pediculated that was difficult to determine, but it seemed firmly attached on one side. There were some symptoms pointing to a myxomatous growth, the rapid progress, its situation, and the uniform enlargement of the uterus; but it did not have that soft, pulpy feeling that myxoma does; there were no particular signs of a carcinomatous growth. Sub-mucous fibroid seemed to answer the abnormality.

Assuming that were it a broad base sub-mucous, its base would gradually be reduced to a pedicle. I therefore determined to hasten the process, by inducing contractions of the uterus under electricity, also to destroy if possible the attachments of the pedicle by the electrolytic action of the negative pole. I placed a cup-shaped negative electrode over the os, and a large flat plate over the abdomen, and gave her thirty milliamperes. This was repeated every four or five days for four weeks, giving at some sittings fifty milliamperes. Occasionally the faradic current was used to induce contraction, and at the last three treatments the intra-uterine electrode was used, passing the same within the uterine cavity against the growth. The patient began having severe pains twenty-four hours after, continuing quite severely with considerable regularity for thirty-six hours. At that time I was called, found the os dilated to admit three fingers, and a hard substance protruding. I placed the patient on her side, introduced Hunter's speculum, dilated the cervix, grasped the tumor with a volsellum, and gradually extracted it. There seemed to be no pedicle.

It proved to be a sub-mucous fibroid about as large as a good-sized orange. The patient recovered rapidly, and is now quite well. In considering the case I am induced to believe that the galvano-faradic current aided much in separating the tumor from its attachments and expelling it from the uterus, and I see no reason why such treatment is not applicable to these growths. I find no mention, however, of electricity being used just in that manner.

Just a word relative to the mucous polypi. These are only an hypertrophy of the villous surface of the cervix. They are always small, bleed easily, red in color, soft and friable. Their origin may be the site of a placental attachment, or the fragments of a placenta, or it may be a cancerous growth.

Allow me now to call your attention to the interstitial myoma proper, and by that I mean one that has so extended as to occupy the entire uterine wall. They are of two varieties, as I have already mentioned, called soft cedematous myoma and nodular myoma, but

the majority are of the former character. These soft tumors are solitary, consist of a great mass of soft uterine tissue that looks and feels like a well-advanced pregnancy, and is covered by a thick and uniform layer of natural uterine tissue. The uterine canal may run up one side, showing that the tumor grew from one side in the wall. The growth rises gently from the pelvis, and acts so like a normal pregnancy that it is difficult to distinguish it.

Tait relates two cases of such tumors, wherein, after opening the abdomen and placing one hand on the tumor and the other against the os, he was not able to determine positively whether it was a natural pregnancy or an œdematous growth. He sewed up the wound rather than risk the removal. In each case it proved to be such a tumor as we have just described.

These tumors are the kind that require hysterectomy, as they grow quite steadily, and may attain an enormous size, weighing as high as sixty pounds. When cut into, a great quantity of serum exudes. They are somewhat gelatinous in consistency. They may occur at any age from eighteen to sixty. I find records of hysterectomy performed at the age of eighteen for the removal of these œdematous fibroids. Again, they may not appear till after the menopause. They generally give more trouble than the other forms of myoma. Hæmorrhage is the most serious symptom, although not always present.

If these œdematous myoma can be discovered *early* they are readily removed by cutting through the uterine wall and shelling them out, but unfortunately we seldom see them till they are too large to thus remove, and require amputation of the entire organ.

The nodular variety of interstitial growths are found multiple. They are seldom, if ever, found in the cervix, but are essentially a disease of the fundus; are very dense, almost cartilaginous; do not yield serum, and creak when cut. They seldom occur before thirty-five or forty years of age, and, while they may delay the menopause, do not occur after it, and will generally pass away after such time. Pain is seldom a prominent symptom.

The constituents of both varieties, however, seem to be an overgrowth of normal uterine tissue, as they contain no immature cells. The last variety to consider is the so-called sub-peritoneal; these have already been defined as connected with the outer aspect of the uterus, and invested with peritonæum. They may or may not be pediculated. Like the polypoid they were originally in the muscular wall itself

(see Fig. 5), but nearer its peritoneal surface than the mucous surface, and thus gradually pushed outward till they lie just beneath the peritonæum (see Fig. 6). They always, with rare exception, spring

FIG. 5.

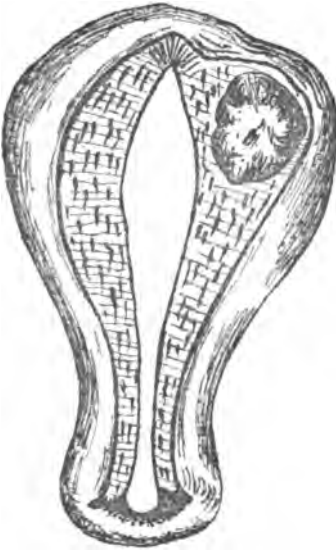
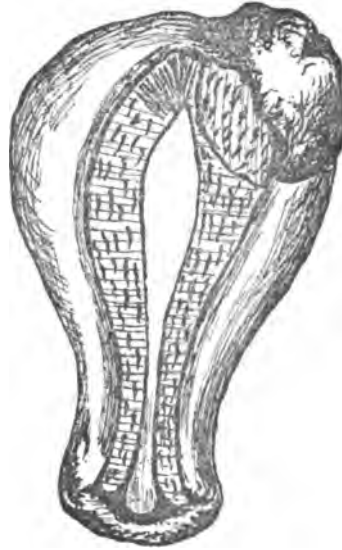
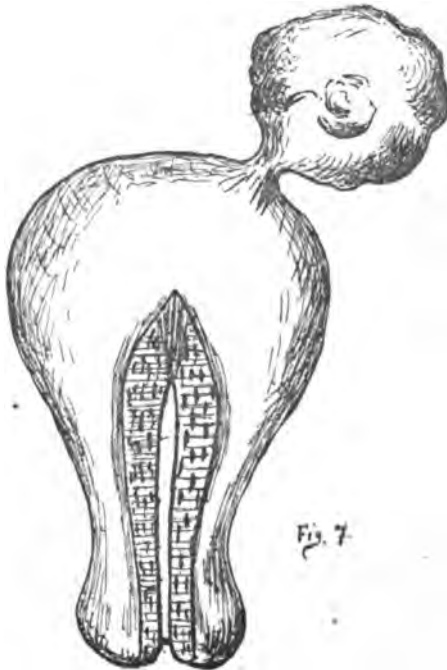


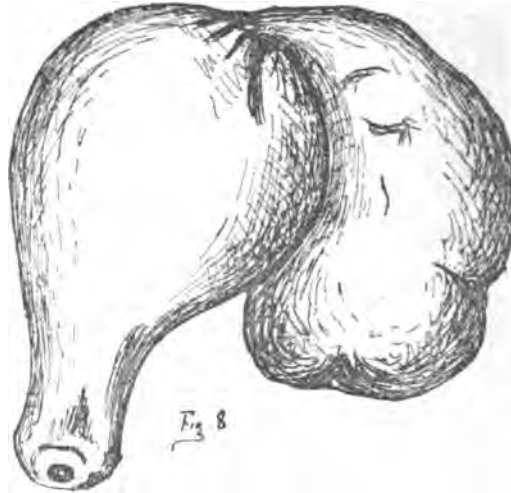
FIG. 6.



from the fundus and very near the upper surface (see Fig. 7). A



peculiarity they show when quite large is that of drawing the uterus upward. Indeed, the vaginal canal may become so stretched that it is with the greatest difficulty the cervix can be felt by a digital examination. A case is reported wherein the cervical canal was six and one-half inches long. Rokatsky says that it is *possible* for complete separation of the fundus and cervix to take place. It not infrequently happens that a pedunculated myoma can be freely outlined beneath the abdominal walls. Its presence may be demonstrated for some time, when suddenly it will disappear, and you flatter yourself it has been absorbed, but a little later you can find it in the posterior cul-de-sac wedged down firmly. The explanation is simply that the pedicle has become longer and more slender till, failing to support the tumor, the latter falls backward like a retroflexed uterus, and there remains (see Fig. 8).



Mrs. K.—Two years before I saw her she was examined by a number of physicians and told she had a tumor of the womb. She could herself feel it distinctly just beneath the abdominal walls. Suddenly it disappeared and neither she nor her physicians could find it. About the same time she began having much backache, difficulty of obtaining a good stool, and general pelvic pain. When I examined her, I found a hard resisting body in the utero-vaginal pouch, bound down closely and about the size of two fists. I regarded it as a sub-peritoneal uterine fibroid, and adherent both to the rectum and fundus.

Upon opening the abdomen and cutting through the peritonæum that invested it, I was able to peel it out from its bed; I then found that it had a pedicle which attached it to the fundus (see Fig. 8).



This I ligated and removed the growth. I was then enabled to understand the cause of its disappearance. It was first an ordinary pedunculated myoma of the fundus; as such it was felt beneath the abdominal walls. The pedicle in time became atrophied, the tumor fell backward between the rectum and fundus, and there formed adhesions from its surface to the surface of adjacent organs.

These growths while yet pedunculated, are quite easy of removal, simply requiring an abdominal incision, ligating of the pedicle and removal, if there be no adhesions.

I shall not go minutely into the treatment of these growths; suffice it to say uterine myoma are not, as has too frequently been regarded, a light affection.

They are more than merely a "lump in the womb." We are discovering too frequently that by their size, hæmorrhage and pressure, death follows.

I am convinced from investigation that the disease is on the increase. I understand that it is unknown amongst the savage women of Africa, yet how prevalent it has become amongst their descendants in America.

*A Few General Suggestions as to Treatment.*—If it be a nodular myoma, and the patient is near the climacteric, no hæmorrhage, no pain, do nothing but wait. If health is failing from either cause, hasten the change by removal of appendages. If it is œdematous, very large, growing more so, health failing, some years from climacteric, consider hysterectomy seriously. I am inclined to think that one gets but little result by removing the ovaries in the œdematous variety.

I wish I could speak more enthusiastically of the use of electrolysis; but while it has been of use in some few cases, it has failed in so many I can only speak of it as a possible palliative.

Spontaneous disappearance has been mentioned frequently in connection with these tumors. While the reports seem to come from reliable sources, yet I am inclined to the belief that their disappearance is after the manner I have mentioned, that of a pedunculated myoma, falling backward into the recto-uterine space.

## THE PATHOLOGY AND DIAGNOSIS OF DISEASES OF THE PROSTATE.

BY CARL V. VISCHER, M.D., PHILADELPHIA.

(Read before the Homœopathic Medical Society of the State of Pennsylvania,  
September 17, 1890.)

It seems as though the prostate gland, although intimately connected with, and in fact a part of the uro-genital tract is frequently forgotten or disregarded. Especially does this seem to be the case in the more acute forms of urethral disease, and only where a hypertrophy is possible or probable is it made the object of a more careful examination.

A few words as to the anatomy of the gland may not be out of place. The prostate is a symmetrical body composed of a median and two lateral lobes, the existence of the former, however, is said by some, never to be present in a normal gland.\* Its structure consists of a dense stroma of unstripped muscular tissue, in the meshes of which are found tubular glands, lined with cylindrical epithelium.

It is tunnelled by the ejaculatory ducts, which open at the floor of the prostatic urethra on either side of the veru montanum, where also the ducts of the gland itself empty. It lies below and in front of the neck of the bladder, surrounding the beginning of the urethra for about an inch of its length, and is enclosed by a dense capsule, with the pubes in front and posteriorly the rectum. It is held in position by the pubo-prostatic and posterior layer of the triangular ligaments. The gland is almost completely surrounded by a plexus of veins.

It is easily conceivable, owing to the relation the gland bears to the urethra, that it is readily accessible to any inflammatory process that may be going on in the canal, not to mention those that may rise primarily in its structure. Aside from the inflammatory conditions to which the prostate is liable, we may have those arising from altered nutrition, such as atrophy, hypertrophy, etc.; although comparatively rare, it may prove not the less interesting to give these a passing notice.

*Atrophy of the Prostate*, although infrequent, is sometimes met with in old age, when we find the glandular element to be the principal seat of the atrophy. It is also found in wasting diseases such as phthisis, and where there is any pressure exerted as from a stone, tumor of the bladder or stricture, which, by causing a damming

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\* Thompson, Morgagni, Lantorini, etc.

back of the urine, increases the pressure. It has also been found in the young when it may be so marked as to cause incontinence.\* Atrophy at times may follow an acute inflammation as in other organs. Double castration has also been known to produce this change. Thompson has shown that atrophy does not necessarily accompany old age any more than does hypertrophy, and that as a rule the gland remains about its normal size.†

*Prostatic Hypertrophy* is a condition that has been so exhaustively discussed, that any further remarks may seem superfluous. Pathologically, however, it presents a variety of forms which may prove interesting. It is probably the most common affection of the prostate found in elderly men. So that Sir Benjamin Brodie was said to remark that "when the hair turns gray and scanty the prostate gland almost invariably becomes increased in size." Hypertrophy, according to Thompson,‡ is never found before the 55th year, after which it is found in about 33 per cent. The most frequent form of enlargement is an increase of the stroma forming a tumor composed of fibro-myomatous tissue, analogous to those found in the uterus; this variety may reach quite a large size. Thompson§ speaks of having seen one as large as a small cocoanut. Another form of hypertrophy is where there is a glandular hyperplasia which in reality is a true adenoma and may undergo carcinomatous changes. In cases of glandular hypertrophy the ducts of the prostate are not infrequently involved and may be the cause of no little difficulty in catheterizing, the tip of the instrument being apt to enter the mouth of a duct.

Especially is this the case when a small catheter is used.

The diagnosis of prostatic hypertrophy, as a rule, presents but little difficulty. It is a disease of advanced life and is never found before the 55th year, after which it may give rise to a variety of symptoms, the principal one being difficulty of urination. This is no doubt a frequent symptom of several pathological changes, but where it is present in the young it is usually due to some inflammatory or nervous condition. In middle life it is commonly found in cases of stricture, but where these conditions can be excluded in those more advanced in life, it will almost invariably be found due to prostatic enlargement. The patient is obliged to pass water

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\* Socin.

† Thompson on *Diseases of the Prostate*, 1873.

‡ Thompson on *Diseases of Urinary Organs*, 1883.

§ *Diseases of the Urinary Organs*, 1883.

frequently, especially at night, the opposite being the case in stone. As a consequence of the hypertrophy there will be more or less retention of urine which sooner or later gives rise to a cystitis, which may prove the most difficult to manage. Subjective symptoms alone may, however, give rise to errors in this, as in most any other disease; therefore it behooves us to make a physical examination in every case of suspected hypertrophy, when, as a rule, it becomes an easy matter to recognize the form of enlargement we have to deal with. In cases of unilateral hypertrophy, the urethra frequently becomes distorted, forming a letter S; here it is where the greatest skill combined with no less patience and a very flexible catheter is required to prove of avail, and, in fact, there are cases where even these measures are unsuccessful. In bilateral enlargement, the calibre of the urethra is also greatly diminished and may be obliterated, making catheterization impossible. Here as in the foregoing form, we may have such an increase in length of the urethra so as to make it impossible to reach the bladder with an ordinary catheter. A prominent third lobe not infrequently leads to retention, acting as a valve over the internal urethral orifice; there are, however, cases reported where quite a large middle lobe caused little or no difficulty. Where it is possible to pass a sound into the bladder, the intravesical condition may be determined quite readily, especially if this is combined with the rectal examination.

*Malignant Tumors of the Prostate* are rather rare; occasionally, however, we may find it the seat of a carcinoma or sarcoma. The former has been principally observed in the earlier years. Nyas described the growth as beginning from the tubular epithelium with relatively little change in the stroma, whereas, Birch Hirschfeld \* found considerable hyperplasia of the stroma with round-celled infiltration, the carcinoma cells being usually found in nests or arranged in strings and mostly of the cylindrical variety. The growth consists at first of small, yellowish white nodules which protrude into the urethra and soon begin to ulcerate, and as a result of which we have more or less severe hæmorrhages. Carcinoma of the prostate, as that of the bladder, is seldom followed by metastasis, the disease spreading by continuity, and so involving the neck of the bladder, seminal vesicles and rectum.

*Sarcomata*, although seldom, are most commonly of the variety

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\* *Pathological Anatomy*, 1887.

known as lympho-sarkom, one case of such being reported as occurring in a child of two years of age.\*

*Tuberculosis of the Prostate* is unusual, excepting as a secondary involvement of tuberculosis of some other portion of the genito-urinary tract, especially the epididymis, and is characterized by a nodular enlargement, the nodules being smaller than those sometimes found in fibrous hypertrophy and undergo cheesy degeneration, oftentimes breaking through and discharging into the rectum, bladder or urethra. The diagnosis is not difficult, as a rule.

*Prostatic Concretions*, accurately speaking, are only found in the ducts of the gland, and are almost invariably present in old prostates in greater or less numbers. They greatly vary in size from those that are to be seen microscopically only, to those of quite large size, T. H. Barker having removed one weighing over three ounces. The smaller ones are round or oval and formed in concentric layers. According to Paulitzky, the concretions are formed by the deposition of albuminoid substances around desquamated epithelium, which changes into an amyloid substance and finally calcifies.

Stilling believes them to be formed from a hyaloid degeneration of the epithelial cells such as takes place after fevers. They may be so numerous as to cause complete atrophy of the gland, the stones remaining in the capsule as if in a sac (Adams). In general, they much resemble biliary calculi.

*Cysts of the Prostate* are very exceptional and are usually formed by a dilatation of the ducts caused by a stoppage from a concrement, or where there is a fatty degeneration of the epithelium lining the ducts, when it is known as a "milky prostate" (Rokitansky). There are a few cases of echinococcus of the prostate reported.†

Coming to the more important affections of the prostate and those which will claim our attention most, we have the inflammatory changes.

Prostatitis may be of two varieties, follicular and parenchymatous; each of these may be either acute or chronic.

*Acute Prostatitis* may be due to several causes, such as traumatism, excessive intercourse, masturbation, or mechanical irritation, as stone or astringent injections, but is by far more common as a sequence or accompaniment of urethritis. According to Montagnon and Eraud

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\* Birch Hirschfeld.

† Lowdell, *Med. Chirug. Trans.*, 1846, Vol. 29.

70 per cent. of the cases are of gonorrhœal origin, when it usually is found to be of the follicular variety. Here the gland is but slightly enlarged and oftentimes but one lobe is found involved. The inflammation tends toward localization, as in most cases one or two nodules about the size of a pea can be made out by rectal examination, which either terminate in resolution or the formation of small abscesses that empty spontaneously into the urethra. This form of prostatitis is prone to develop at or about the same time that the inflammation invades the posterior urethra, which as a rule takes place the latter part of the third week, unless the process is precipitated by premature injection. The diagnosis of acute prostatitis may often be made by the presence of a constant desire to urinate, which is the more marked the more acute the inflammation is, so that in the more severe forms, the patient scarcely has time to respond to the call, the urine passing involuntarily. The discharge apparently remains unaltered, but if Thompson's test with two glasses be made it will be seen that the second glass is decidedly cloudy, perhaps as much if not more than the first; this is owing to well known reasons. If the urine in the second glass is allowed to precipitate the latter will be found to consist of mucus, together with numerous small hooked-shaped particles. On the addition of a few drops of acetic acid, the cloud may disappear owing to the phosphate, an excess of which is frequently found in connection with this trouble. At the end of micturition the patient experiences sharp pains, which radiate from the prostate into the rectum, perinæum, and sometimes the testicles, and are due to the contractions of the neck of the bladder in forcing out the last of the urine.

Rectal examination reveals the condition previously described, together with marked tenderness. The disease tends toward resolution, unless influenced by some indiscretion on the part of the patient or otherwise, when it passes into the chronic stage.

*Chronic Prostatitis*, besides being due to the foregoing may arise as a complication of chronic urethritis. When the gland may be decidedly enlarged or considerably smaller than normal, the structure becomes spongy and exceedingly vascular; in advanced cases we may have numerous small abscess formations, the mouths of the ducts are wide, containing mucus; besides these we may find numerous small cavities opening on the floor of the prostatic urethra, the mucous membrane of which is atrophied and highly vascular. The glandular epithelium undergoes cloudy swelling. As to the symptoms of chronic prostatitis, there are many in common with the acute

form, only not as marked, such as the tenesmus which causes a source of constant trouble, most every act, such as walking, sexual intercourse, etc., making the patient feel as though he must empty his bladder at once; this, although not as marked as the acute stage, seems to be more constant. Defecation is often accompanied by a thick milky discharge from the urethra, which many believe to be sperma, so that one frequently finds a supposed spermatorrhœa, is in reality due to a chronic prostatitis. Besides these we have symptoms of sexual irritation, which function is decreased, the patients often complaining that an orgasm is impossible or is accompanied by a sharp pain in the posterior urethra and rectum. Another, and indeed a very common symptom, is a premature orgasm, the patient having good erections but ejaculation takes place before the act can be accomplished, immediately following which the organ becomes flaccid. Nocturnal emissions are also frequently complained of.

This is quite naturally followed by mental depression. In some inveterate cases of prostatorrhœa, spermatozoa are at times found with the prostatic fluid. There may also exist a general hyperæsthesia of the genital organs. Patients complain of sharp burning pains during micturition which may lead one to suspect acute inflammatory changes, or stricture, as not infrequently spasms of the urethra are present. Besides these, we may have many of the well-known symptoms of sexual neurasthenia. In regard to the diagnosis of chronic prostatorrhœa, it will suffice to say that the passage of a sound will elicit unusual tenderness in the prostatic urethra, and the secretion which is quite diagnostic of the trouble will be found adhered to the beak of the instrument on its removal, after which it can also be readily squeezed out by slight pressure along the deep canal. The test with the glass may prove the second portion of urine quite clear, but in it will be seen floating small hook-shaped casts of the prostatic ducts; this together with the subjective symptoms is sufficient on which to base a diagnosis.

Microscopically, the secretion consists of abundant pus cells, polygonal and cylindrical epithelium, together with the so-called Böttcher's sperm crystals which consist of fine needles, the base of which is composed of phosphatic salts, which Schreiner has shown to be pathognomonic of prostatorrhœa. To demonstrate these most satisfactorily it becomes necessary to obtain the secretion free from urine. A drop of one per cent. sol. of phos. of ammonia is now added to an equal quantity of secretion, which is allowed to dry slowly under a cover-glass.

*Parenchymatous Prostatitis* is usually the result of either one of the above forms or of traumatism. The gland becomes enlarged, at times so much, as to cause partial or complete retention of urine. It is exceedingly tender, and gives a boggy sensation to the finger. Painful defecation is not an uncommon symptom. The disease runs a rather rapid course, either terminating in resolution or abscess formation in a week to ten days. In case of the former, the symptoms gradually subside; whereas in the more destructive form, the symptoms usually increase in severity until about the seventh or eighth day, when the patient is taken with a severe chill followed by a rapid rise of temperature. Examination now reveals that a semi-fluctuating mass which may point and break in one of several directions, unless surgical interference gives free vent to the pus. Although the most frequent point of rupture is into the urethra (64 times in 102 cases, Legond), it may break into ischio-rectal space, rectum, peritoneal cavity, perinæum or burrow and point in the inguinal region or various other directions; one case being reported where pointed at the umbilicus, so that at least this form of the disease is much more serious than ordinarily supposed. Of 114 cases tabulated by Legond, 34 resulted fatally. It is therefore advisable always to keep this in mind, and in every case of gonorrhœa with a sudden rise of temperature to carefully examine the prostate.

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### THE BRAIN SYMPTOMS OF SULPHATE OF QUININE.

BY W. M. BUTLER, A.M., M.D.

(Read before the New York State Homœopathic Medical Society, October 1, 1890.)

No drug is more extensively employed by the allopathic school than sulphate of quinine. The list of maladies said by its advocates to be relieved by its administration is almost as numberless as the ills to which mankind is subject. Malarial, yellow, typhus and typhoid, puerperal and scarlet fevers, angina pectoris, hay fever, asthma, all forms of neuralgia, acute rheumatism, enlargement of the spleen, phthisis, pneumonia, pleurisy, gangrene of the lungs, laryngismus stridulus, whooping-cough, erysipelas, urticaria, scrofulous ophthalmia, insanity, epilepsy, tetanus, gangrene and mortification, cancrum oris, scurvy, cholera, diarrhœa and dysentery are all asserted



by different authors to have been cured by this marvellous panacea. In fact one might infer, if he were to be guided by allopathic writers upon the subject, that all any physician could desire would be a case full of quinine to combat any form of disease. Nor is this idea of the all-curative properties of this drug limited to the medical faculty alone. Among many of the laity the same opinion prevails, and a bountiful supply of quinine is reckoned among the household necessities. Fully convinced of its cardinal virtues, it is not deemed necessary to call in the medical adviser for the ordinary ailments of the family until the sufferer has been thoroughly plied with quinine. One might naturally infer, from the universality of its use, that it was classed among the harmless agents of the Pharmacopœia, yet the list of symptoms which its most strenuous advocates admit that it is capable of producing when given in too large doses or when the individual is especially susceptible to its effects is somewhat appalling. Not to speak of the vomiting and purging which it may produce, we find mentioned vertigo; noises in the ears of various kinds, as of insects humming, distant waterfalls, the ringing of bells or the striking of a clock. These noises may be accompanied by slight deafness, or the deafness may become complete.

Less common, but liable to occur, are optical illusions, intolerance of light, amblyopia, mydriasis and even blindness; headache of greater or less severity, with a curious sensation as if the top of the head were coming off. In others the cerebral symptoms may increase to positive mania. In some cases collapse and coma occur, occasionally accompanied by convulsions. This list of ills is doubly emphatic coming, as it does, from the mouths of its friends. Among the homœopathic provings of the drug we find great despondency, with a feeling as if some evil were impending; disinclination to mental work; anguish, with loud sobbing and weeping; furious delirium, with screaming and jumping out of bed at night; confusion of the head; whirling in the head, like a mill-wheel; violent pains of various sorts through different parts of the head, especially in the supra-orbital regions; dilatation of the pupils; bright lights and sparks before the eyes; black spots before the eyes, dimness of vision, blindness, amblyopia and amaurosis; deafness, with roaring, ringing, buzzing, hissing and sounds of bells in the ears. We also find sleeplessness, or uneasy, restless sleep, disturbed by dreams.

With such a formidable array of serious nervous symptoms liable to be produced by its administration, one would suppose that its use by non-professionals would be tabooed, and that medical men would

be somewhat chary in their selection of subjects to whom it should be given, and careful in their dosage. Yet too often, after a superficial diagnosis, the patient, regardless of his peculiar idiosyncrasies, is ordered quinine. If the nervous symptoms of the drug are produced, they are ascribed to the disease, and the dose increased. How many trifling maladies are thus transformed into dangerous illnesses or how many unfortunates are in this manner hurried into untimely graves no one can know, as the ones who make these mistakes are usually masters of the situation, and no one capable of the task can sit in judgment upon their work. Fortunately, however, these victims of allopathic malpractice occasionally fall into homœopathic hands and are rescued, and from these we can form some idea of the multitudes who must continually suffer in a like manner without relief. An instance of this kind some time since came into my own practice, the details of the case being as follows :

November 17, 1888, was called to see W. F. De V., printer, married, 24 years of age, with the following history :

Tuesday, November 8th, although not feeling well, worked during the day, and in the evening took a long walk. Upon returning home had a slight chill, which was followed by a high fever which lasted all night. Wednesday morning, an allopathic physician was called, who pronounced the disease malarial or typhoid fever, he could not say which, and prescribed quinine and whiskey (the exact dose not known), to be given every two hours, alternately. Never having taken either whiskey or quinine, as soon as the patient commenced to take them, he complained of continual ringing and noises in the ears, as if steam cars were running through his head. For the next two days, the pains in the head continued, severe and unceasing, the treatment remaining the same. Friday night, commenced to think that people were talking about him, and desired to know what his wife and sister were quarreling about. The physician now pronounced the case typhoid fever, and increased the amount of quinine and continued the whiskey. Saturday and Sunday, much depressed. Sunday night, suddenly sat up in bed ; said it was getting dark, and he could not see, and he was going to die. After this, did not want any one to come towards him or speak to him. Pain and ringing in head continued uninterruptedly. Monday, continually gazed out of the window, without apparently seeing anything. About 4 P.M., a friend came in, and when she attempted to put her hand on his head, he said, "do not touch me, your hand is the hand of death," and then commenced to shout and cry, and was with difficulty restrained in bed. Tuesday and Wednesday, very nervous and excitable, and did not know his friends. Thursday, about 1 A.M., commenced to call his wife, in a sing-song, but did not recognize her when she came to him. Kept this up for two hours. All at once,

got out of bed, and went to the window, but was induced to return to bed. Suddenly, springing out of bed, he ran around the room, then rushed to the window (which was in the second story of the house) and jumped out, landing upon a clothes-line in the yard. Although the rain was pouring in torrents, the patient received no apparent injury. I was called in the succeeding forenoon. Upon examination, I found the patient entirely unconscious. Face pale, and covered with a clammy sweat. Pulse and temperature considerably below normal. (Unfortunately, I have mislaid the temperature chart, so that I cannot give the exact figures.) A most careful examination revealing not the slightest sign of typhoid fever, I concluded that the patient was suffering from over-drugging with quinine. The quinine was discontinued (from the size of the bolus, the amount given being, I should judge, about 20 grains every two hours), and diminished the whiskey from two to one tablespoonful. At my second visit, in the evening, found that the patient had rallied considerably, and was decidedly wild and maniacal. Discontinued the whiskey. November 18th: patient slept little; full of delusions and hallucinations of sight and hearing; very wild, and had to be restrained in bed; sang most of the time.

This excitement continued for about two weeks, attended by most obstinate sleeplessness, which had prevailed during the entire illness, when, through the influence of appropriate homœopathic remedies, it entirely passed away, leaving the patient in an extremely weakened condition, requiring about three weeks more of care and medication before he was able to resume his work.

How a reputable physician could make such a rank error in diagnosis, it is difficult to understand, as in the whole history of the case before he came into my hands, I was unable to elicit any symptoms diagnostic of typhoid fever, and none occurred while he was under my care. Had the case received the proper homœopathic remedy at the onset, there is not the shadow of a doubt but he would have been at his work within a week.

That this patient was peculiarly susceptible to the influence of quinine there can be no doubt, nor can there be any less doubt that he would have found an early grave had he been much longer kept under its influence—and this form of treatment is called Scientific Medicine.

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VAGINISMUS.—Baas reports an interesting case apparently due to a large and thick hymen that had been only partially ruptured and had become exceedingly sensitive to the least touch. He prescribed a 10 per cent. cocaine cerate and complete abstinence from all sexual attempts for two weeks. At the end of this time she was much improved and soon after was cured.—*Centralblatt für Gynäkologie*, No. 41, 1890.

## EDITORIAL.

## KOCH'S DISCOVERY.

THE great subject uppermost in the professional mind at the present time is the announcement that Koch has discovered a remedy that will stay the ravages of tuberculosis. As is well known to our readers, the daily press for some little time past has contained full and supposed to be authentic accounts of the successes attained by it. The manner in which the various points pertaining thereto have been presented savors largely of the sensational. Not to be outdone in enterprise by the secular press, the great medical weeklies have been competing actively with each other that each may present the latest news sooner than his contemporary. The *Medical News* in its issue of November 15th, published a translation of Koch's entire article as published in the *Deutsche Medicinische Wochenschrift* of the day before, a feat made possible only by a liberal use of the cable. The *Medical Record* has sent Dr. Max Einhorn to Berlin that he may pursue investigations of the "new cure" at headquarters, giving him instructions to cable weekly reports. Medical colleges and universities have likewise sent their representatives to the field of action. Many physicians have cabled for a supply of the wonderful virus; many more have written for the same. Two thousand physicians are said to be in Berlin for the purpose of learning the great secret. Never before has the medical mind been in such a state of excitement as at the present. Great as is this excitement it is but natural. It is estimated that there are at present two hundred thousand consumptives in the United States. In other portions of the world there are many more. To these as especially interested in the discovery should be added the many sufferers from tubercular diseases of the skin, bones and serous membranes. In Philadelphia, one of the healthiest cities of the world, one-fifth of the deaths in adults are from consumption. Should, therefore, Koch's discovery benefit but one-tenth of those for whom it was intended it will be a great boon to suffering humanity.

The remedy and its mode of preparation are as yet a profound secret. All that we do know concerning it is that it is probably a ptomaine of the tubercle bacillus. This secrecy on the part of

Koch and his colleagues we must condemn, especially in view of the fact that some of the latter are making use of the monopoly in their knowledge of the "cure" to enrich themselves, a perfectly natural thing to do under the circumstances. We cannot consider the ostensible reason for secrecy a valid one, namely, that the importance of the discovery requires that all experiments should be carefully and accurately conducted, lest incompetent experimenters detract from its merit or inflict much bodily injury on the confiding subjects of their experiments. If the discovery is one of merit its minutest details cannot be made public too soon. There are men everywhere perfectly capable of making the preparation as carefully as are those connected with Koch's laboratory. That harm may be done by the injudicious use of the remedy goes without saying; that it will be done ultimately, even when the exact nature of the lymph and the *technique* of its applications are fully announced, is equally certain. Seekers after notoriety will most assuredly apply it to cases to which it is not adapted. Koch's conservatism will not prevent them from performing their ill-advised experiments. We see on the other hand many reasons why a complete exposure of the "cure" should be made. Then able men of all nationalities will soon confirm it; they may even aid Koch in its elaboration. Thus will the treatment be placed on a firm footing much sooner than it could be under other circumstances.

Regarding the value of the discovery we would say that it is yet too early to express an opinion. We think that the profession should not be too hasty in accepting it. Two great medical sensations are yet fresh in our minds. One of these was announced two years ago, namely, the cure of phthisis by the rectal injection of sulphuretted hydrogen; the other was the so-called "elixir of life" discovered (?) by Dr. Brown-Sequard, of Paris. Both of these excited widespread interest, second only to that at present displayed over the latest news from Koch's laboratory, and both have been exploded as medical fallacies. The former raised false hopes in the breasts of many phthisical patients, and thousands of physicians have as a souvenir of the craze a useless sulphuretted hydrogen apparatus. The "Elixir" was a sensation for a month, put in practice by men seeking notoriety, and dying a natural death after having done incalculable harm to the subjects of their experiments.

Koch, however, is a very different man from either Bergeon or Brown-Sequard. The very fact that he has been so careful hitherto in all his statements makes any assertions he may now make, how-

ever extravagant they may seem at first sight, worthy of the greatest respect. A careful perusal of his paper as republished in the *Medical News* shows that the daily press has greatly overestimated the benefits claimed for the treatment. The ultimate effect of the inoculations is to produce a necrosis of the living tuberculous tissue, the dead mass then being removed either by surgery or by natural processes. The remedy has no effect on the tubercle bacilli themselves.

The most satisfactory experiments thus far made have been those performed on cases of lupus. The diseased tissue has invariably broken down under the treatment and been cast off, and perfect cures have almost invariably followed. Tubercular processes on an external surface like the skin are very different matters from tuberculosis of the lungs or serous membranes. The question arises, what if the application of the remedy causes multiple necrotic foci in the tuberculous organs? Can surgery or unaided nature relieve the sufferer? May the end not be hastened by the attempt to cure? We should most certainly hesitate before making any experiments on persons suffering from peritoneal or cerebral tuberculosis. These, of course, are but our impressions, and can have but little weight in the absence of definite knowledge as to the "cure." When Koch says that phthisis in its incipient stages can be most certainly stopped by the remedy his words are entitled to consideration; but at the same time we must not forget that his enthusiasm may have biased him in his opinions. Then, too, if the cure does not (as is said) destroy the receptivity of the system to the tubercle bacillus, what assurance is there that the cure will be permanent? Certainly this is a most important matter. Everything depends on the receptivity of the patient, for all of us are constantly taking the tubercle bacilli into our lungs.

If Koch's discovery should enable us to cure tubercular processes in their incipency, then it will be a great boon indeed, even though it leaves the advanced cases in their present state of hopelessness.

Two thoughts are suggested by our subject. The first is that pulmonary phthisis is not by any means invariably fatal. How often have we in our autopsies discovered pulmonary cicatrices, the results of old lesions? How often have we had cases of phthisis apparently hopeless and make excellent recoveries under good treatment? We echo the sentiments of many physicians when we say that consumption is frequently cured, especially when taken in its early incipency, and the physician goes about his work with a

fixed determination to cure. Proper hygiene aided by careful medication can and will do much.

The second thought is regarding the method of inoculation. Our readers have no doubt noticed that the hypodermic syringe has been the instrument used in this, as in other recent inoculation experiments. Vaccination has always been performed by scarification of the part, with subsequent rubbing in of the virus. Which is the best method? Which causes the least discomfort, and which gives the best chances of success?

In closing we advise our readers to preserve a strict conservatism regarding this new cure. Let them not lose sight of the fact that our knowledge of the method shows that it is radically different from anything that has ever before been proposed. Let us hope, however, that all our brightest hopes may be realized, and that the fell-destroyer, consumption, will shortly be a thing of the past. Surely, then, humanity's greatest benefactor will be Robert Koch.

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#### DR. W. S. GEE.

DR. W. S. GEE, Professor of Materia Medica in the Hahnemann Medical College of Chicago, and associate editor of the *Medical Advance*, died on the evening of November 11th at Chicago. His death was not altogether unexpected. For some time past he has been suffering from consumption. He sought relief by a stay in Colorado. Not gaining in health, he returned home about two months ago.

Dr. Gee was yet a young man. He was born in Clinton, Mo., August 6, 1856. He came to Chicago in 1879 and entered the Hahnemann Medical College, from which he graduated in 1881. For one year he was house surgeon to the hospital, after which he established himself in practice at Hyde Park. Since 1885 he has occupied the chair of Materia Medica and Institutes in the Hahnemann College. He leaves a wife and two children.

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#### NOTICE.

ATTENTION of subscribers is called to the fact that the news items for the current year have been so arranged that they can be separated from all advertising matter. In preparing the journal for binding, they should be thus separated, and bound either as an appendix or as an independent journal.

## GLEANINGS.

### GENERAL MEDICINE.

CONDUCTED BY

S. LILIENTHAL, M.D.,

E. M. GRAMM, M.D.,

CLARENCE BARTLETT, M.D.,

W. W. VAN BAUN, M.D.,

**EPIDEMIC INFLUENZA AND INSANITY.**—In stating his conclusions from a study of cases reported from various asylums, Harrington observes that forty-eight cases have been recorded in which an attack of insanity followed immediately or in a short time on an attack of influenza. In thirty-one cases the influenza acted as an exciting cause of the insanity, predisposing and other exciting causes being clearly made out. In seventeen cases the influenza was the only assignable cause of the insanity. The author expressed as his opinion that if these seventeen cases were analyzed thoroughly, it would be found that those without predisposing causes would be greatly diminished, and that we might readily approach near a conclusion made by Kræplin, namely, that the influenza alone is not sufficient to occasion the development of a psychosis. Of the total forty-eight cases, sixteen recovered. Considering that in hospitals the average number of recoveries in new cases is only from fifteen per cent. to twenty per cent., the recovery of thirty-three per cent. of these cases is worthy of remark.

Cases of insanity excited by the influenza have shown a greater tendency to prompt recovery or improvement than is usual in recent cases. In most cases the improvement has been coincident with the abatement of acute bodily symptoms and the return to physical strength and health. The cases studied could be classified into the following groups:

(1) Cases of simple depression and hypochondria. Many such instances were no doubt seen by those in general practice during the epidemic, but in which the mental disturbance did not proceed far enough to demand hospital treatment.

(2) Cases in which the emotional disturbance was carried farther than in the last group, resulting in acute forms of mania and melancholia.

(3) A considerable portion of cases which developed on the basis of bodily exhaustion and depression of the nerve forces, namely: The cases of delirious mania, febrile delirium, and especially those of acute confusional insanity, which seemed to be the type towards which the symptoms in many cases have inclined.—*Boston Medical and Surgical Journal*, August 7, 1890.

**THE TREATMENT OF PULMONARY PHTHISIS.**—Koch's views on the treatment of phthisis pulmonalis have received interesting support from the experience of a chemist, Herr Reuter, made public in April last at a full meeting of the Lower Austrian Industrial Union. Koch, it will be remembered, maintained at the Berlin Congress, that among the remedies capable of bringing the malady to a standstill, the salts of gold and silver are of the greatest value, and that among these the first place must be given to "cyan-gold." Reuter, who, as director of great *fabriques* of metallic wares at home and abroad, paid particular attention to those in which the articles in question were galvanically gilded or silvered, observed that in the latter industry the *employés* who had consumptive or tubercular symptoms, some, indeed, who suffered from hæmoptysis, found marked relief in their work, and continued to improve so rapidly that in a few weeks their return to health was assured. The favorable impression made on Reuter as to the curative effects of the gold and silver industry on phthisis, he found confirmed by the testimony of *employés* of every age in these establishments—men, young and old, who had the well-known symptoms of pulmonary consumption, even at an advanced stage, rapidly getting well as they continued from week to week at work. Further investigations strengthened that impression still more, till he had satisfied himself that for the disease in question a healing virtue resides in the prussic acid generated particularly in those workshops where "cyan-kalium" are used. Impressed by Koch's views, the Medical Association of Vienna has since bestowed special consideration on Reuter's ex-



perience embodied in the paper read before the Lower Austrian Industrial Union last April, and, while admitting the confirmation given to those views by Reuter, it is of the opinion that the honor of priority in discovering the efficacy of gold and silver salts in the treatment of phthisis pulmonalis belongs undoubtedly to the latter.—*The Lancet*.

**PRURIGO AS A FAMILY AFFECTION.**—Dr. Sokoloff, House Surgeon to the Moscow Hospital, records the history of a family, in which, of six children (aged from 1 to 12), three (two girls and one boy) were suffering from a severe general prurigo. In each instance, the symptoms had first appeared about six months after the child's birth to gradually attain their maximum intensity about the fifth year of the patient's life, after which the itching as gradually decreased. The symptoms were always intensified during summer, and under the influence of heat in general. All the three patients were fair and fat, while those not affected were of dark complexion and lean.—*British Journal of Dermatology*, October, 1890.

**EFFECTS OF WATER-DRINKING ON THE HEART.**—Prof. Koranyi, of Budapest, has published a series of observations on the effects upon the heart of drinking water in various quantities and of various temperatures. He found that the action on the heart takes place very quickly after taking the water: cold water slowing the heart and generally raising the blood pressure, while hot water quickens the heart and always raises the blood pressure. In one case, thirty seconds after drinking water at 39° F, the blood pressure rose 15 mm.; it then began to fall until, in seventeen minutes, it was 17 mm. below the normal; it then began to rise again, regained its original height in twenty minutes. Tepid water appeared to lower the blood pressure. The colder or hotter the water the more the rapidity of the heart's beats and the blood pressure were affected, and the longer the effects lasted.—*The Lancet*.

**PROFESSOR KOCH AND THE TUBERCLE BACILLUS.**—Prof. Koch's experiments form the chief subject of conversation and conjecture in Berlin medical circles. Absolute secrecy is still maintained as to the remedy itself, but several facts are known that help to give an idea as to its nature. The remedy is no drug that can be bought at the chemist's; it is obtained by a process similar to that by which vaccination lymph is got. By means of this substance the development of the tubercle bacilli in the animal organism is arrested, while a peculiar mode of treatment renders the body safe against fresh invasions of the bacillus. The first experiments on animals were carried on by Prof. Koch in his own laboratory. His assistants knew nothing of the nature of these experiments, but they observed that the animals under the professor's treatment remained alive and well, while other animals—likewise under his observation, but not treated—sickened and died. The professor's son-in-law, Stabsarzt Pfühl, then began hospital experiments at the Charité under Koch's own supervision. When it became known that these experiments were to be transferred to another hospital, people shook their heads and thought the sign anything but hopeful. The fact is, however, that the removal took place because Koch required more absolute seclusion for his experiments than he could find at the Charité. At last week's meeting of the Gesellschaft für innere Medizin Prof. Leyden read a paper on hospital arrangements, in the course of which he mentioned Koch's experiments as having been crowned with the fullest success. It is hoped that before many weeks go by, the publication so eagerly looked forward to will be made. Dr. von Esmarch, Koch's assistant, will for this half year give the course of lectures on hygiene, thus leaving Koch free to give his whole time to his experiments.—*The Brit. Med. Jour.*

**URGENT DYSPNOEA IN AN INFANT AGED ONE YEAR; OCCURRING SUDDENLY AND TERMINATING FATALLY WITHIN AN HOUR AND A HALF; DUE TO A CASEOUS GLAND WHICH HAD ULCERATED ITS WAY INTO THE TRACHEA.**—Mr. R. W. Parker recently called the attention of the Clinical Society of London, to the case of an infant in arms, previously in excellent health. The mother was in a butcher's shop buying. Suddenly, and without previous warning, the baby was seized with urgent dyspnoea. The mother ran off to the nearest doctor, who, recognizing the urgency of the case, sent it to the East London Children's Hospital. On its admission, the serious nature of the case was explained to the mother, and tracheotomy was urged. The mother would not consent until she had consulted her husband; while gone the urgency became so great that tracheotomy

was performed without waiting for the consent of the parents. Temporary relief was afforded, but the foreign body which was supposed to have caused the trouble could not be found. The child died within one hour and a half after the attack. At the post-mortem examination a caseous gland which had ulcerated its way into the trachea, was found just above the bifurcation occluding one bronchus entirely. There had been no symptoms to call attention to such a condition.

**LACTOSE AS A DIURETIC IN HEART DISEASE.** (*Journal de Médecine de Paris.*)—Patients who are suffering from cardiac dropsy are generally submitted to milk diet, and often take no other nourishment; in order, however, to derive from milk the needful quantity of albuminoid, it is necessary to take as much as five litres. Five litres contain about 250 grammes of sugar of milk, and some portion of this sugar is eliminated by the urine; there is glycosuria. All patients are not able to consume so considerable a quantity of milk. Amongst the constituent elements of milk, sugar alone possesses, in any marked degree, diuretic properties. Several medical authorities, including Dr. Germain See, advise that patients suffering from cardiac dropsy should be given daily 100 grammes of lactose dissolved in two litres of water. This treatment does not succeed when the dropsy is of renal origin, and only fails in cardiac dropsy when it is complicated by Bright's disease. Patients bear this treatment all the better because they can take concurrently with it any nourishment they like. The treatment must be continued from eight to ten days; it must then be suspended and again resumed. The solution of lactose may be rendered more appetizing by the addition of peppermint water or brandy. Glycose possesses the same diuretic action, but lactose is to be preferred because it undergoes more rapid transformation in the system.—*The Provincial Med. Jour.*, November, 1890.

**INFLUENCE OF THE INGESTION OF ALBUMINATES ON HEALTHY AND DISEASED RENAL FUNCTION IN MAN AND ANIMALS.**—Opinions on this subject from high authorities differ; while some favor an albuminous diet in renal affections and consider it the best means of improving nutrition, others affirm that food of this character irritates the affected kidney, increases albuminuria and renal insufficiency, and when carried to extremes, it may even produce a transitory albuminuria in persons with healthy kidneys. Prior undertook a long series of experiments to solve that question. He found that the coagulated white of egg, even when taken in excess, either alone or with other food, does not cause albuminuria nor any renal irritation, thus differing entirely from the raw white of egg. Healthy persons may take the latter with impunity, but nephritics, even when they take it with other food, increase their albuminuria and kindle up afresh their renal affection. When taken exclusively it may cause albuminuria even in healthy persons. Differentiation by individualization is of the utmost importance. In scarlatinous nephritis a nitrogenous alimentation causes retention of urea in the organism, without appreciable modification of the arterial pressure. Saturnial nephritis stands well an albuminous alimentation, even large quantities of whites of eggs, but when exclusively taken for several days such diet increases the albuminuria and arterial tension considerably. In the atrophic kidney a mixed alimentation, strongly azotic (hence raw eggs taken exclusively) may increase the albuminuria and decrease at the same time the excretion of water, of urea and of water in the urine, while arterial pressure rises. Patients with chronic parenchymatous nephritis bear without inconvenience food rich in albumin, but raw eggs alone may produce renal insufficiency and increased arterial pressure. In interstitial nephritis, azotic ailments are not only well borne, but may give a considerable improvement, manifesting itself by diminished albuminuria and increased energy of the heart. A dozen boiled eggs may even take the place of meat, but an exclusive egg diet is never advisable. After all, raw egg and too much azotic food ought to be banished from the diet of nephritic patients and still we must not neglect to particularize every case.

In the presence of any renal affection we must try the reaction of the patient and give such food as represents a moderate quantity of azotic food and then find out in which part of the kidney the lesion prevails. When the epithelium of the Malpighian glomerule is affected, we will see a diminution in the quantity of urine and of the urinary salts, though the excretion of urea may be more or less sufficient. Here azotic food, meat, milk, well-cooked, and soft boiled eggs, can be allowed. Neither too much milk nor too much water ought to be taken, for we ought to husband

the epithelium, whose function consists especially in the excretion of the water. When, on the contrary, we have to deal with a retention of urea the food must be relatively poor in nitrogenous elements and the milk diet finds then one of its most rational indications.—*Semaine Méd.*, 44, 1890.

**ORIGIN OF HERPES ZOSTER.**—M. Féré, in the *Revue de Méd.*, reports four cases of herpes zoster, which occurred nearly contemporaneously among his 150 epileptic patients at the Bicêtre. The first was a young man of nineteen, who had had a few violent epileptic attacks without any unilateral symptoms. The herpes was confined to the left side of the thorax and the left side of the face, and along with it he had some spasms of the left corner of the mouth, illusory impressions of persons approaching him from the left side, and some contractions and sluggishness of the left pupil. The left side of the tongue also was much more thickly furred than the right. The temperature ran up to 107° F. at first, but all the morbid symptoms gradually subsided in a week. In the three other cases, in middle-aged men, the most prominent symptom was severe pain, with tenderness on pressure, down the spinal column. M. Féré is led to conclude from these and similar observations that the most probable cause of the herpetic eruption is a slight epidemic cerebro-spinal meningitis, which may be widespread, but perhaps only of sufficient irritative power to cause the herpes at the root of one or two nerves. Such a pathological condition would not be surprising in infectious diseases, for in them some forms of meningitis are not rare.—*The Practitioner*, October, 1890.

**GOOD EFFECT OF IRON AND DIGITALIS IN HEART DISEASE.**—Dr. Arthur Foxwell reports a case of adherent pericardium; mitral and tricuspid incompetence, orthopnoea, ascites and general anasarca, great congestion of the liver, greatly benefited by the use of iron and digitalis, combined with a milk diet and rest in bed. The patient, a soldier, 54, was a large, robust-looking man, with evident orthopnoea and cyanosis of nose and lips lasting for months. The liver reach to one inch above the umbilicus and the edges felt hard, rounded and granular. The lungs presented wheezy râles and rhonchi. Cough troublesome, and the expectoration scanty. Expiration prolonged and harsh over the upper part of the chest. The heart's impulse was diffused and could not be located by palpation. Auscultation showed the apex to be one inch below and half an inch external to the nipple, beneath the sixth rib. Superficial dulness extended one inch to the right of the edge of sternum. An indistinct systolic murmur was heard at the apex and over the centre of the præcordium; it was not conducted into the axilla. The pulmonary second sound was accentuated. Under treatment two systolic murmurs were developed. The urine presented a trace of albumin and blood. Sp. gr. 1025, varying in quantity from 6 to 10 ounces. Under the continued use of the treatment the heart steadily improved, the hepatic enlargement rapidly subsided, and the urine rapidly increased to 40 or 50 ounces, and the patient was able to resume his occupation.—*The Birmingham Medical Review*, October, 1890.

**THE BLUE OEDEMA OF HYSTERIA.**—Sydenham long ago called attention to this subject, when he said hysteria attacks also the external parts as well as the internal ones, and pain and swelling are found in the extremities. We meet two symptoms in the swellings of dropsical patients, namely, that they are greater in the evening and a strong pressure causes an indentation in the skin. On the contrary, the hysterical swelling is worst in the morning, and pressure never leaves any mark. The swelling attacks mostly one leg only, which is hardly ever the case in the white dropsical oedema. In hysterical oedema the temperature is also lowered several degrees, and it shows a bluish coloring of the skin. Some authors call it a neuropathic oedema, because it is sometimes combined with alterations of sensibility (anæsthesia or hyperæsthesia), with motor troubles (paralysis and contractures). It always needs a thorough examination to differentiate this blue oedema of hysteria from other nervous disorders, as syringomyelia or Raynaud's disease. The absence of fever shows that it is not of inflammatory origin. Alone and by itself such a blue oedema would not give a therapeutic indication; tonics, massage and hydrotherapy, and especially hypnotic suggestion are used with benefit in the Salpêtrière.—Prof. Charcot, in *Progrès Méd.*, 41, 1890.

(What else does this blue tint mean but a languid circulation, a venous stagnation, and involuntarily we think of pulsatilla, with its deficiency of red-blood corpuscles and its languid pituitous state all through the system, or of the salts of magnesia, of sepia and sulphur, and when we give them in a high potency and with great assurance, the psychic influence will aid us in doing wonders.—S. L.)

## GYNÆCOLOGY AND OBSTETRICS.

CONDUCTED BY

GEO. R. SOUTHWICK, M.D., AND E. W. MERCER, M.D.

**PREGNANCY IN BOTH UTERI IN DUPLICITY OF THE GENITALS.**—Dr. Althen reports a very rare instance of double uterus and double vagina, in which pregnancy in each uterus occurred at about the same time. Abortion took place spontaneously at about the eighteenth week.—*Centralblatt für Gynäkologie*, No. 40, 1890.

**THE TREATMENT OF ENDOMETRITIS.**—There has been recently considerable discussion in France for and against the use of the curette. P. Reynier has abandoned the use of the sharp spoon and concentrated solutions of chloride of zinc, after an unsatisfactory trial of them. He now employs the ordinary curette and follows it by cauterization with a 5–10 per cent. solution of chloride of zinc or kreosote, or a 10 per cent. solution of carbolic acid. Concentrated solutions of chloride of zinc may produce serious injury and atresia of the cervix uteri.—*Gaz. des Hôpitaux*, No. 39, 1890.

**THE TREATMENT OF RUPTURE OF THE UTERUS.**—Prof. Leopold advises delivery through the natural channel only when the presenting part has entered the true pelvis. Mutilating operations are preferable to the use of the forceps. Laparotomy is necessary if the child has escaped into the abdominal cavity. The rupture should not be increased by efforts at delivery. The treatment of the rupture depends on the degree of hæmorrhage. If there is but little internal or external bleeding the edges of the wound are approximated by drawing down the uterus with volsellum forceps, introducing iodoform gauze to the fundus uteri, making a thick pad in the uterine cavity behind the laceration and by means of a large pad on the abdomen and a firm binder, force the uterus into ante flexion. If the hæmorrhage from the vagina can not be controlled, or there are signs of internal hæmorrhage, laparotomy is imperative, the bleeding places must be ligated and the edges of the rent be brought into apposition. Special pains should be taken to compress the effusions of blood beneath the peritonæum by strips of iodoform gauze, the ends of which can be brought out in the lower end of the abdominal wound. At the same time a similar tampon should be placed in the uterus and vagina. Leopold also believes that laparotomy is indicated if the patient has been delivered through the natural channel, has had the tampon inserted, and still continues to bleed from the uterus. If the uterus is considerably inflamed, or if hæmorrhage cannot be arrested otherwise, it is best to remove the uterus by Porro's method.—*Centralblatt für Gynäkologie*, No. 40, 1890.

**THE INFLUENCE OF DRESS IN PRODUCING MOVABLE KIDNEY IN WOMEN.**—F. von Korányi concludes from results of clinical observation and the study of statistics, that wearing high heeled shoes and heavy clothes about the waist are important factors in causing movable kidney. The effect on the position of the body and the relaxation of the peritonæum is too obvious to require further explanation.—*Centralblatt für Gynäk.*, No. 41, 1890.

**MASSAGE IN GYNÆCOLOGY.**—Ziegenspeck has published an excellent account of it in the *Sammlung Klinischer Vorträge*, No. 353–54. The chief thing aimed at in all displacements of the uterus and in pelvic inflammation, is to restore the mobility of the uterus. Dr. Prochownik, of Hamburg, has also written this year a small work on the same subject which shows much originality.

**TREATMENT OF STUMP AFTER MYOMOTOMY.**—Dr. Kocker of Berne, inserts a number of fine silk ligatures around the stump just above the ligatures on the spermatic arteries. These ligatures are drawn tight and tied after the myoma is removed. They do not interfere with the healing of the flaps and afford an additional safeguard against hæmorrhage.—*Centralblatt für Gynäkologie*, No. 41, 1890.

**INTERNAL TREATMENT OF FIBROID TUMORS OF THE UTERUS.**—It may interest the readers of the *HAHNEMANNIAN MONTHLY* to hear that an eminent French gynecologist, Lucas Championnière, has found that sabina is a very helpful remedy for the

hæmorrhage and pain accompanying these tumors. He uses half a centigramme each morning for three weeks in each month.—*Centralblatt für Gynäkologie*, 41, 1890.

**TRENDELENBURG'S POSITION FOR LAPAROTOMY.**—Prof. Leopard of Dresden, has adopted this position for his operations and highly commends it, especially for difficult salpingotomies and adhesions deep in the pelvis. The intestines gravitate away from the pelvis, permitting an excellent view of the field of operation.—*Centralblatt für Gynäkologie*, No. 42, 1890.

**DRAINAGE AFTER LAPAROTOMY.**—At Säger's clinic in Leipzig, aseptic bent glass drainage-tubes are used with very fine openings on the sides. Small strips of iodoform gauze are loosely introduced a little more than half-way down the drainage-tube, which empty the tube by capillary attraction. The wound is dressed with iodoform gauze and wood wool. The tube is usually removed on the third day.—*Centralblatt für Gynäkologie*, 41, 1890.

**THE INDUCTION OF ABORTION BY AN ELECTRIC DRY CUP.**—Dr. H. W. Freund in Strassburg, proposed to excite labor pains by closures of the galvanic current through a so called dry cup on the nipple connected with the negative pole and a flat electrode positive pole, on the abdomen over the fundus uteri. Dr. A. A. Amann, Jr., experimented with the electricity in this manner, using seven to twenty-six milliamperes. He easily provoked uterine contractions, but was unable to induce premature labor at eight months pregnancy in two cases as well as in a third case in which the period of pregnancy is not stated. He found the method of some value in delayed labor due to weak contractions of the uterus.—*Centralblatt für Gynäkologie*, No. 43, 1890.

**THE DIFFERENTIATION OF GONOCOCCI.**—Steinschneider has written an excellent article on the subject and recommends the following process for diagnosis: The preparation on the object glass remains twenty-five or thirty minutes in anilintgentian-violet, is washed and placed five minutes in a solution of iodide of potash. It then soaks in alcohol till the color is removed. It is now washed and dried and again colored with Bismarck brown or Löffler's methylene blue. It must not be more than a few seconds in the latter solution. Preparations treated in this manner will show the gonococci in a light tone of color while the other diplococci remain colored very dark or black.—*Centralblatt für Gynäkologie*, p. 769, 43, 1890.

**ANOMALIES OF MAMMARY SECRETION.**—Prof. Landau reports three cases of anomalous mammary secretion. Case 1 showed that the absence of the ovaries does not prevent lacteal secretion. A young and robust woman, who had never been confined nor aborted, had castration performed on account of dermoid cysts of the ovaries. Eighteen months after the operation she felt stitches in her breasts, and soon afterward they commenced to secrete a considerable amount of milk. Case 2.—A woman of 24 years complained that her babe of six weeks, only nursed from her right breast and refused to nurse from her left one. Both glands were well formed and discharged plenty of milk, but while the milk of the right breast had its natural sweetness, that of the left had a decidedly salty taste. Under the microscope no difference could be detected in the milk of either breast. Case 3 was one of discharge of blood from the mamma, coinciding more or less with menstruation. In fact it might be considered a vicarious menstruation. The woman was 46 years old. Under the microscope the milk showed many red blood-globules, corpuscles of colostrum, fat drops and lymphoid cells; no epithelial cells, nor crystals. Chemically the fluid showed a neutral reaction and contained albumin, fat and lactose, demonstrating a mixture of milk and of red blood-globules. Examination revealed a slight retroflexion of the uterus which was mobile; all the other genital organs were perfectly sound. A bandage was applied over the breast, and when this was removed after three days, all discharge had stopped, and did not return, nor did she show any swelling in the breast.—*Deut. Med. Wochenschrift*.

**CARCINOMI UTERI PROLAPSI.**—So far as is known there are only four cases published. The extreme rarity of it rather opposes the theory of local irritation of a lacerated cervix producing epithelioma, as the prolapsed uterus is especially exposed to local irritation. The patient was eighty-one years of age, had never borne a child, and had a total prolapse of the uterus for twenty years. Ullman successfully performed total extirpation of the uterus.—*Centralblatt für Gynäkologie*, No. 43, 1890.

**ICHTHYOL FOR DISEASES OF WOMEN.**—Dr. H. W. Freund recommends ichthyol as an excellent remedy which has marked soothing and absorbing properties for all local inflammations. He has had remarkable success with it for chronic parametritis, chronic and subacute perimetritis with exudations, adhesions or cicatrices; inflammations of the tubes and ovaries; erosions of the cervix and pruritus of the external genitals.

He employs the remedy externally and internally; for the latter purpose, he gives 0.1 gm. three times a day at first and later in doubled doses. For external use he combines it with glycerine (ammon. sulpho-ichthyol. 5.0, glycerine 100.0) and applies it on cotton tampons for the vagina. For the purpose of stimulating absorption he employs a salve (lanolin equal parts) or as a soap (ammon. sulpho-ichthyol. 8.0 sapon. virid, 80.0) rubbed on the abdominal walls or as a suppository (0.05-0.2 with butyr. cacao) introduced into the rectum. For erosions of the cervix uteri, he paints on the pure ichthyol. For pruritus, he uses the salve mentioned above or a ten per cent. watery solution painted on the surface.—*Schmidt's Jahrbücher*, Bd. 228, No. 10, 1890.

**THE TREATMENT OF PLACENTA PRÆVIA.**—Braxton Hicks condemns the vaginal tampon. He recommends in marginal placenta prævia and complete dilatation of the cervix, rupture of the membranes and if the head does not descend in spite of pains, the application of the forceps or version. If the os uteri is small, he recommends careful separation of the placenta from the uterus at one side with the index finger and if the orifice does not dilate, the use of Barnes's rubber dilators. The best treatment of all is always version by internal and external manipulation.—J. Braxton Hicks, *Schmidt's Jahrbücher*, No. 10, 1890.

Prof. Th. Wyder on the *treatment of placenta prævia* writes in a similar manner. He believes that the tampon is uncertain in arresting hæmorrhage, is often the carrier of infection and that the use of the tampon followed by version when the cervix is sufficiently dilated causes great loss of time. Version is his remedy *par excellence*. Combined version if pains and hæmorrhage are present and the cervix not sufficiently dilated for internal version. If a segment of the head has already entered the pelvis and the pains are good and strong, rupture of the membranes often suffices for marginal or lateral placenta prævia.—*Schmidt's Jahrbücher*, No. 10, 1890.

**DEATH DUE TO THE SIMPLE IRRITATION OF THE CERVICAL CANAL OF THE UTERUS.**—M. Vibert (*Progrès Médical, Paris*).—A young woman was brought into the hospital and was found to be dead on admission. At the autopsy, nothing abnormal could be discovered, no sign of violence and all the organs seemed healthy. The external and internal genitalia were uninjured, the uterus contained a fœtus of about four months' growth, and there was no indication of commencing labor. But it came out in evidence that the woman had been the victim of repeated attempts to procure abortion, and that the operator, a midwife, had at length passed the jet of an ordinary enema syringe within the cervix, but before she could inject any fluid, the woman fainted and never recovered consciousness, dying a few minutes afterwards. M. Leblond, commenting on the case, remarked that catheterism of the uterus often produced severe reflex disturbance with a tendency to syncope.—*The Prov. Med. Jour.*, November, 1890.

**DECAPITATION BY A CORD FOR IMPACTED TRANSVERSE PRESENTATION.**—Dr. E. W. Branch reports a case of impacted transverse presentation in which it was evident that the only resource was decapitation. Not having any instruments for the purpose with him, he was obliged to resort in his emergency to the use of thick twine. The patient was thoroughly anesthetized. He then groped for and found the child's neck; and tying one end of the cord loosely around the third finger of his left hand, he pushed it up with the cord trailing along the palm, until he got his finger well around the neck. He then gradually slipped the end of the cord off his finger, and worked it around the neck until he could seize and pull it down, enclosing the neck in a loop, both ends being out of the vagina. He then inserted a Sims' speculum to save the vagina, and seizing one end of the cord in either hand, he sawed away. Decapitation was accomplished in an incredibly short space of time. In the discussion following the report of Dr. Branch's case, Prof. A. R. Simpson spoke approvingly of the device employed, which was really a modification of Pajot's decapitator. In the case reported, the neck was driven down so far as to require no special instrument for the placing of the cord about the child's neck.—*Edinburgh Medical Journal*, October, 1890.

## OPHTHALMOLOGY, OTOTOLOGY AND LARYNGOLOGY.

CONDUCTED BY

CHAS. M. THOMAS, M.D.

**THE REMOVAL OF FOREIGN BODIES FROM THE NOSE.**—S. Johnson Taylor, M.D., describes a method of removing foreign bodies from the nose. It consists in introducing the nozzle of an India-rubber bag full of air into the nostril which does not contain the foreign body. The nozzle should well fit the nostril, and can easily be made to do so by closing any remaining chink with the left forefinger and thumb, just as is done when administering a Politzer's inflation. The nostril containing the foreign body is left patent. Then the patient, if old enough to understand, is made to take a sip of water, and during the act of swallowing the air is forcibly expressed from the bag, and as the communication between the nose and pharynx is shut off, the air returns by the other nostril, and forces out the foreign body. In the case of a very young child the bag is squeezed whilst the child is crying, during which the nasal and oral cavities are shut off from one another. He has just employed this method in the case of a child aged three years, with a large round, smooth white bead, larger than a good-sized pea, in the left nostril. Gentle but unsuccessful efforts had been made to remove it. The parts were very small, swollen, and tender, with a little blood-stained discharge, and it looked like a case for chloroform and a troublesome manipulation with scoops, forceps, or wire snares. The above method was tried, with the most satisfactory results, the bead being forced out at the first attempt.—*The Lancet*, November 8, 1890.

**BORIC-ACID MASSAGE IN DISEASES OF THE CONJUNCTIVA.**—In the treatment of granular and follicular ophthalmia and similar conditions, Dr. W. M. Beaumont (*Lancet*, October 18, 1890), recommends rubbing the conjunctiva with finely pulverized boric acid. The method is carried out as follows: First, the upper lid is everted in the usual way, and the boric acid is thickly sprinkled on the palpebral conjunctiva. The powder is then rubbed into the conjunctiva with the end of the index finger for five or ten seconds, after which the remaining boric acid may be washed away with a soft brush dipped in "lead lotion;" or if there is not much discomfort it may be allowed to remain. The lower lid is then treated in the same manner. In some cases the first few applications cause pain, but after one or two applications tolerance is established. In the earlier applications pain may be prevented by instilling cocaine solution. The procedure may be repeated on succeeding or on alternate days. The condition of the conjunctiva after two or three applications is that of healthy reaction. Dr. Beaumont then reports three cases of trachoma in which this method of treatment gave excellent results.

**THE RELATION OF NASO-PHARYNGEAL DISEASE TO CATARRH OF THE MIDDLE EAR.**—At the eighth annual meeting of the American Rhinological Association, held in Louisville, Kentucky, October, 1890, Dr. Emmett Welsh, of Grand Rapids, Michigan, called attention to the intimate and inseparable relationship existing between naso-pharyngeal disease and catarrh of the middle ears. He reminded the members of the Association that repeated attacks of sub-acute otitis are often directly referable to some mechanical obstruction or inflammatory condition of the naso-pharynx, and that the latter condition—the cause—should be treated. This is best illustrated by children who suffer from recurrent attacks of otitis media; when the membrana tympani is found inflamed, the child breathes with difficulty and chiefly through the mouth, and an adenomatous growth is discovered in the vault of the pharynx.

A spur upon the septum may excite tinnitus aurium, when, of course, treatment of the ear alone would be useless.

**ADMINISTRATION OF MORPHINE BY THE NOSTRILS.**—At the same session of the above association, Dr. Carl H. von Klein, of Dayton, Ohio, read a paper on the administration of morphine by absorption through the mucous membrane of the nose. He had employed this method in more than one hundred cases with very satisfactory results. It is simply snuffed into the nasal chambers, and the dose is divided into two equal parts. He finds that the action of the drug is more prompt when thus administered than when given by the mouth, or hypodermically.—*Medical News*, October 25, 1890.

**TUBERCLE OF THE LARYNX.**—In view of the recent discussion on this subject by the British Medical Association, Dr. Hunter Mackenzie, of Edinburgh, says: "I have no reason to believe that lactic acid, menthol, iodoform, or any such drugs have a specific action upon the tuberculous lesions of the larynx, more especially when applied in the intermittent way, which alone is practicable in the case of that region. From prolonged experiment and observation I know, as already stated, that their action on the germs is absolutely *nil*, and I believe they have no greater claims even as palliatives to places in the armamentarium of the laryngeal surgeon than are possessed by chloride of zinc, carbolic acid, hydro-naphthol, and many others."—*Glasgow Medical Journal*, November, 1890.

**METHOD OF FEEDING IN LARYNGEAL INFLAMMATIONS WITH DIFFICULT DEGLUTITION.**—Dr. D. G. Woodvine, of Boston, Mass., in the October number of the *Journal of Ophthalmology, Otology and Laryngology*, tells of a novel and successful method of feeding patients suffering from laryngeal disease, with difficult and painful deglutition, even of liquids. The food recommended is milk, beef-tea, and thin gruels. These are to be placed in a small pitcher on the floor at the foot of the lounge; the patient to procure a piece of rubber tubing about eighteen inches long, then lie down on the lounge upon the stomach, with the feet thrown up over the arm of the lounge and the face and head over the foot of the lounge, the right or left cheek toward the floor, decided partly by experiment, and partly depending upon the situation of the laryngeal inflammation, and the situation of the greater degree of laryngeal obstruction. The patient is then to place one end of the rubber tubing in the pitcher and the other end in the mouth, and by suction draw the fluid through the tube into the mouth, and let it flow along the inside of the cheek and the lower jaw, until it reaches the œsophagus, then swallow.

Persons who cannot swallow in the usual way, or if so, only with great pain and discomfort, have experienced no difficulty by this method. Dr. Woodvine's explanation for this relief is, that by taking this position the pressure of the atmosphere is relieved from the windpipe, and the head being turned to one side, the liquid is directed to one side of the glottis, and cannot produce coughing.

**HYDROBROMATE OF HYOSCYAMINE; ITS POWER OF RAPIDLY OVERCOMING SPASM OF ACCOMMODATION.**—A solution of hydrobromate of hyoscyamine of the strength of one per cent., acts as a powerful agent in paralyzing the ciliary muscle, even when in a state of spasm; a single instillation is enough; paralysis is complete in from eighteen to thirty minutes; the effects pass off in from three to five days; it gives rise to no disagreeable symptoms in children and young adults, and when carefully used is safe even in the old, where, of course, it is seldom, if ever, necessary to be used for spasm of the accommodation. It appears to be the most powerful of all mydriatics, one instillation doing as well as repeated instillations of atropia sulphate, and instead of requiring from ten days to three weeks to pass off, the effects pass off in five days at the longest. In old persons it is found best to use a very small drop, on account of the unpleasant symptoms produced, viz.: dizziness, nausea, and a tendency to fall forward. Two old men treated with the hyoscyamine became unconscious and remained so for ten or fifteen minutes, but recovered without any disagreeable after-effects. In children and young adults no symptoms of the drug were produced except a diffused haziness of the fundus of the eye, which was to be plainly seen with the ophthalmoscope, from half an hour to two hours after the drug had been used. In spite of this condition of the fundus, the acuity of vision was not impaired, but, on the contrary, sight was improved in several cases. Whether this was due to the stimulation of the nerve fibres, or to the correction of irregular astigmatism, was not determined.

In treating neglected cases of iritis, in which strong and broad adhesions have formed between the iris and the capsule of the lens which have resisted the repeated instillations of strong solutions of the sulphate of atropia, duboisia and homatropine hydrobromate, and even the use of the crude sulphate of atropia, they are readily and completely torn apart by instilling a one per cent. solution of the hydrobromate of hyoscyamine.—N. L. MacBride, M.D., New York, in the *Journal of Ophthalmology, Laryngology and Otology*.

**ADENOID VEGETATIONS IN THE VAULT OF THE PHARYNX AT DIFFERENT AGES.**—Luc and Dubief point out that whereas there is a very general agreement that adenoid vegetations are most frequently met with between four and



six years of age, there is less certainty as to the epoch at which they first appear, and especially as to that at which they diminish and disappear. As to the first point the authors have nothing new to say. The youngest child upon which they have had occasion to operate was two years old. Many others, however, have been operated upon at earlier ages than this. They maintain that their disappearance before the age of twenty is not by any means so constant as most descriptions of the subject imply. In proportion as we learn to diagnose adenoid vegetations, their presence in the adult will be less uncommon.—*London Medical Recorder*, October 20, 1890.

**TREATMENT OF "VOICE TROUBLE" IN PROFESSIONAL SINGERS.**—Dr. Louis A. Bull, in the *Journal of Ophthalmology, Laryngology and Otology*, October, describes a form of throat difficulty in professional singers, due largely to the deprivation of oxygen in the dressing-rooms, the irritation of the spectacular stage fire and the draughts. He uses for its cure locally a spray of a 25 per cent. solution of *pinus canadensis*, and gives *mercurius solubilis* 1x until the liver and bowels act well, this procedure often relieving the congestion in the throat. The *mercurius* is followed by any indicated remedy, but the best results are obtained from *ferrum phosphoricum* 3x, given in hot solution. *Calcareo phosphorica* is given later as a tonic remedy. Enforced rest and superalimentation are also enforced.

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## GENERAL SURGERY.

CONDUCTED BY

W. B. VAN LENNEP, M.D., ASSISTED BY CARL V. VISCHER, M.D.

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**INTRACRANIAL LESIONS.**—Keen presented an exhaustive paper on this subject at the last meeting of the New York State Medical Society. He treated the subject under the following heads:

(1) **INDICATIONS FOR OPERATIVE INTERFERENCE.**—One and the larger class of cases present *pressure symptoms* due to abscess, tumor, effusions, hæmorrhage, fractures with depression, gunshot wounds and lacerations the result of contusions. The phenomena produced by such lesions are first, impaired intellectual function, the patient becoming dull and stupid and finally comatose; or speech, hearing, or sight may be affected. Second, disturbed motility, certain muscles becoming paretic or paralyzed. Third, changes in sensation over smaller or larger areas. Fourth, changes in the optic disk and other portions of the fundus oculi. These symptoms must be present more or less prominently and completely in all cases of intracranial pressure. To them will be added localizing symptoms, which are of the greatest value, and the special symptoms of each lesion, as cerebral vomiting, headache and convulsions with tumors; subnormal temperature, cerebral vomiting, otitis media or a traumatism in abscess; in injury followed by an interval of lucidity and then coma; in hæmorrhage from the middle meningeal artery; age, atheroma and no traumatism in apoplexy. Should a lesion producing pressure, which must prove fatal, be located, be differentiated from other conditions producing similar phenomena, and be accessible, operative interference becomes a clear duty. Another class of cases present functional disturbances (for want of a better term), such as epilepsy, with or without gross and appreciable lesions, inveterate headaches, insanity and other mental disturbances, as well as arrested development. The indications for operative interference here are not so clear. It may be called for first, if the disease endangers life, growth, or mental development, or so destroys comfort as to make life not worth having. Second, all other means, medicinal, dietetic and hygienic, must have failed. Third, the danger to life from the operation must be such as to make it a reasonable risk. Trephining *per se* is not especially dangerous with the modern technique; opening the dura adds but little to the danger, and excision of brain substance, while it increases the risk, is justifiable if it gives hope of material improvement. In both classes of cases, if the danger be great and if a fatal result be likely to follow without interference, exploratory trephining should be undertaken with this restriction, that the *probable* location of the lesion should be decided upon before operating.

(2) **TECHNIQUE OF OPERATIONS ON THE BRAIN.**—*Shaving.*—The head should be shaved for the purpose of making out scars of which there may be several, although there is a history of but one traumatism. A case is cited in which the lesion was under the lesser scars. *Sublimate solution.*—This should not be applied to the shaven scalp in greater strength than 1 to 2000 for fear of producing pustules. After the brain is exposed boiled water should be substituted not so much on account of a possible poisoning but because the antiseptic lessens the electrical reaction of the cortex. *Hæmorrhage.*—A semi-recumbent position and the preliminary use of morphine and ergot will tend to lessen this. The local use of cocaine and antipyrine (10 per cent.) is no more efficacious than hot water, and besides, it is not so much the oozing as the venous hæmorrhage that is troublesome. Hot water should not be over 120° F. or it may injure the brain substance. The main reliance is the catgut ligature and the vessel should if possible be double tied before division. Traction on the ligature should be moderate and equal on both ends. Hæmostats are apt to tear away. No vessel should be cut near the edge of the opening which should be ample in size in order to allow us to cope successfully with the bleeding. Hæmorrhage from the sinuses (longitudinal or lateral) or from the large veins near them is always alarming and often fatal, not only from the direct loss of blood but also from the shock. The wound in a sinus can either be packed, or the edges seized with hæmostatic forceps which are left in place for two or three days, or a ligature applied on either side of the opening. Bleeding from the cut edge of the bone can be controlled by a putty used by Horsley, *i.e.*, yellow wax one part and vaseline four parts; to this is added five per cent. of carbonic acid. *Drainage.*—This depends on the amount of oozing. If the hæmorrhage is completely controlled it may be dispensed with. In suppurative cases it should of course be used and continuously. *Exploring for abscesses.*—This is best done with the grooved director and should be accurately described, *e. g.*, in the direction of the opposite pupil, an inch above the opposite auditory meatus, etc. *Avoidance of shock.*—The time consumed is one of the most important shock-producing elements. To save time the periosteum is raised with the flap. Time is saved, too, by using an inch or an inch and a quarter or half trephine and enlarging the opening with rongeur forceps. This is preferable to using very large trephines which become fastened in the bone and cannot be adapted to the curved surface of the skull and the different thicknesses of the bone. The surgical engine is not a practicable instrument. The battery should be used in every case to identify the convolutions exposed, and the distance of the spot stimulated from the median line, the fissure of Rolando, etc., carefully noted. The current should not be too strong. The dura can be closed with interrupted or continuous sutures. Rest, external heat, strychnine, alcohol, digitalis and atropine may be used to prevent and relieve shock. *Replacing the bone.*—As a rule no ill effects follow such replacement and it serves as a protection. The resulting surface is usually flat, however, not arched like the rest of the skull, hence in obscure cases of headache, etc., in which the value of trephining probably lies in an alteration of the intracranial pressure, the bone had better not be replaced. Should it be decided to replace it the button must be kept in 1 to 2000 sublimate solution at 100° to 105° F. The entire button can be put back to save time, or if it is much thickened, it can be cut into small pieces. Or a decalcified bone plate may be substituted as suggested by Senn.

(3) **RESULTS.**—In considering these, fractures are excluded, but more frequent operative treatment is urged not only to immediately save life, but also to prevent later disorders, such as epilepsy. *Abscess.*—Trephining should be the rule in these cases, and it is not a question of percentages as every case is lost under the old method of treatment. The difficult question is where to trephine, and this can only be answered by further advances in localization. *Tumors.*—The same holds true here as with abscesses regarding percentages as every case must die. The results are furthermore encouraging, a number of patients recovering and remaining well. Some have died, others have had recurrences of the growth, and unfortunately in others the tumor was not found or did not exist. Hence accuracy of diagnosis is still to be sought for. If possible the size of the growth should be made out approximately, as some have been found too large for removal. It is also desirable to know whether the lesions are single or multiple, infiltrating or encapsulated, superficial or deep. The advisability of attacking tubercular and syphilitic growths is still a question; this is especially so with the former, which are more apt to be multiple. Both have been removed successfully. In the cerebellum, unless the tumor be

small and accurately diagnosed, it cannot probably be removed with safety.

*Epilepsy.*—In the traumatic form the results have been very encouraging, and even in the idiopathic, they hold out some hope. In a few there is no result, good or bad; a large proportion are benefited; about one-fourth are cured, and a very small percentage die from the operation. It is noteworthy that the paralysis following the excision of even a motor centre is only temporary. *Hæmorrhage from the middle meningeal artery.*—This accident is amenable to surgical treatment even without fracture. The trephine should be applied one inch behind the external angular process at the level of the upper border of the orbit; failing to find the clot here another opening should be made over the other branch, that is at the same level below the parietal boss. *Inveterate headache.*—Trephining may be justifiable in cases that have resisted all other known means and make life unbearable.

*Mania.*—An exploratory operation in mania following traumatism has occasionally been followed by relief. *Arrested mental development.*—It is only in those cases in which this condition follows a traumatism that operation offers any encouragement. —*Medical News*, November 1, 1890.

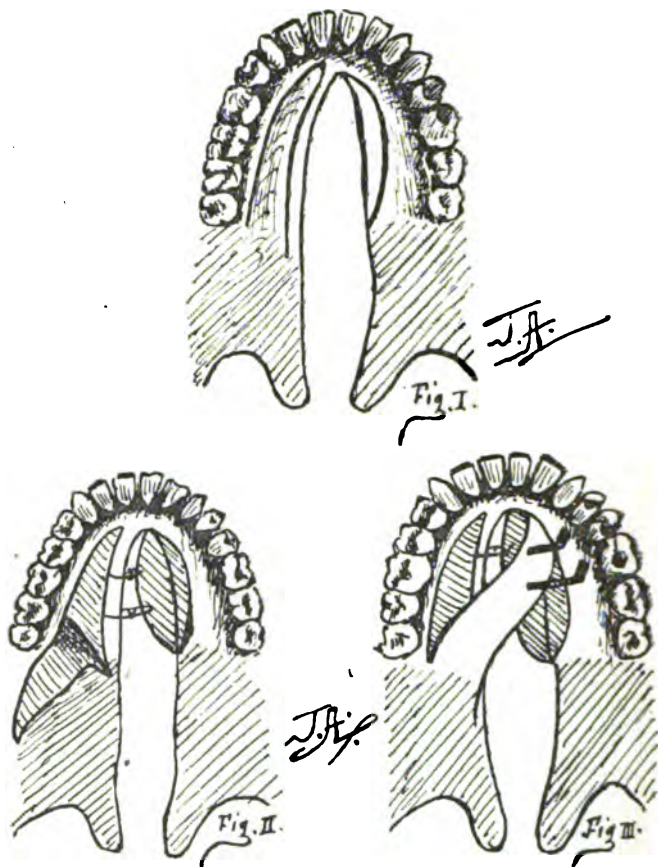
**THE SURGICAL TREATMENT OF ACUTE INTESTINAL OBSTRUCTION.**—J. Greig Smith, in a recent paper on this important subject, makes a plea for the early transfer of these cases to the surgeon. While the causes of obstruction are varied and numerous, clinically we need simply consider the condition of the patient and his capacity to bear operation, and the special state of the intestinal tract and its power of self-recuperation. Frequently the typical operation must give way to modified procedures, and patients who are too collapsed to stand a grave operation may be first saved from death and then brought back to health by successive small operations. The cases met with are usually of three kinds:

(1) Patients on whom an ideal operation can be done. The obstruction is of short duration; there is vigorous and free vomiting; intestinal contractions may be seen through the parietes; abdominal distension is not sufficient to prevent deep respiration, these being 20 to the minute; the pulse is not over 110. While the expression is anxious, the features are not drawn and sunken, and the skin, although moist, is not cold and clammy. The abdomen is generally resonant, and intermittent gurgling can be heard, which is most marked at one point; there is little or no tenderness, and palpitation and rectal examination give negative results. An enema containing brandy is given, and the patient thoroughly anesthetized. A two-inch incision is first made in the linea alba below the umbilicus. Through this the intestines are inspected and the coil selected that is most distended and congested. This is followed in the direction of increasing distension and congestion and will usually lead to the point of obstruction. The cause of the obstruction is then treated according to well-understood principles, and, when removed, a rush of gas from the distended into the empty bowel takes place, and there remains nothing further to do but close the abdominal wound.

(2) Patients who can bear a complete operation, but with certain precautions and additions. The obstruction has lasted for a week or more; vomiting is less vigorous and less frequent; the distension is greater but the walls are lax and intestinal contractions are no longer visible; the face is drawn and pinched and the skin cold and clammy; the pulse is 120 or more, and small and wiry. Anæsthesia is full of risk not only increasing shock, but also because it tends to induce vomiting. The stomach tube should hence be first used, and anæsthesia kept up no longer than is necessary. The cause of the obstruction is relieved as in the former class, but it should be remembered that as the intestines are distended with fluid the loop nearest the obstruction will sink down and not present at the opening. After the cause of obstruction is removed the intestinal contents do not move on as the over-distended bowel is paralyzed and cannot contract; besides the distended bowel is kinked at its numerous acute flexures. The contents must be evacuated thoroughly and the intestine enabled to contract. The anæsthesia is stopped and the patient enveloped in warm blankets; a distended but inflamed loop of bowel is brought out and fastened to adhesive strips by two quill sutures on each side, an inch apart. Infection of the abdomen is prevented by smearing the junction of bowel and parietes with an antiseptic ointment. The outer coats of the intestine are incised and an aspirating needle pushed into the bowel. By patiently kneading for an hour or two the abdomen will become quite flat. The intestine is then closed, disinfected and replaced, and the sutures, previously inserted, and the abdominal wound tied.

(3) Patients in a hopeless condition. Any severe operation and even the anæsthetic will kill. A small opening is made and the bowel attached by quill sutures, opened and thoroughly emptied as above.—*British Medical Journal*, October 11, 1890.

**CLOSURE OF THE HARD PALATE.**—J. N. C. Davies-Colley proposes a method for closing clefts of the hard palate which is adapted especially for infants, in cases in which the ordinary operation has failed, where the cleft is too wide to be bridged over by the ordinary operation. Reference to the cuts will explain the steps of



the operation. (1) A triangular flap is raised from the bone on the wider side. The outer border begins just inside the posterior end of the alveolar process and runs forward to the insertion of the incisors; the inner border runs backwards one-eighth of an inch outside the margin of the cleft, and extends into the soft palate. (2). An incision is made at least one-sixth of an inch from the other side of the cleft running from its anterior extremity to the end of the hard palate. The soft parts are raised from the bone, turning a flap upward. (3) The last flap is attached to the opposite side of the cleft by catgut sutures partially closing the opening. (4) The apex of the triangular flap is carried across and fastened by wire sutures to the outer edge of the incision on the opposite side. The subsequent treatment is like that after the ordinary operation. The tongue serves as a splint to hold up the flap; the catgut sutures are left to take care of themselves; the wire sutures are removed in five or six weeks.—*British Medical Journal*, October 25, 1890.

# MONTHLY RETROSPECT

## OF HOMŒOPATHIC MATERIA MEDICA AND THERAPEUTICS.

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CONDUCTED BY

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**SILICA COMPARED IN NERVOUS HEADACHE.**—There are a few remedies which we have had occasion to compare with silica in the nervous headaches of women, where the pain ascends from the occiput into the head. These are *menyanthes*, *paris quadrifolium* and *strontiana carbonica*. The pain of silica ascends from the nape of the neck to the vertex and thence into the supraorbital region. It is worse from any noise, motion, or concussion, and better from wrapping the head up warmly. Under *menyanthes* the headache also comes up from the nape of the neck and extends over the head. There is a bursting pain, as if the membranes of the brain were tense and were pushing the skull open. This pain is distinguished from that of silica by the fact that it is relieved by pressure rather than warmth. *Paris quadrifolium* also has a headache which arises from the nape of the head and produces a feeling as though the head was immensely large. *Strontiana carbonica* approaches the nearest to silica of all these headache remedies. It produces a headache coming up from the nape of the neck and spreading thence over the head, and this pain is relieved by wrapping the head up warmly. Just exactly like the silica headache, but under strontium we have the distinguishing feature that this neuralgic pain begins lightly and increases gradually to its greatest intensity and then gradually declines.—*Homœopathic Journal of Obstetrics*, September.

**STAPHISAGRIA** is often a valuable remedy in the ovarian irritations of nervous, excitable women. Particularly is it valuable in the hypochondriacal moods of this class of women when an ovarian irritation arises during the absence of the husband, from allowing the mind to dwell on sexual subjects.—*Homœopathic Journal of Obstetrics*, September.

**BELLADONNA** is especially useful for enlargement and induration of the axillary glands occurring in females at the climatis.—*Homœopathic Journal of Obstetrics*, September.

**PULSATILLA** is almost always the remedy in the cystic symptoms that accompany pregnancy. It is not a first-class remedy in true cystitis, but is adapted to the transient bladder symptoms that frequently annoy the pregnant woman.—*Homœopathic Journal of Obstetrics*, September.

**SENECIO AUREUS.**—Farrington describes this drug as especially suitable to nervous, excitable women who suffer much from sleeplessness, traceable to uterine irritation, as from prolapse or flexion of the uterus. With regard to the sympathetic bladder symptoms, there is much distress at the neck of the bladder, causing pain, burning and dysuria. After the onset of the menstrual flow these cystic symptoms become modified or cease, thus showing the reflex relation existing between the menstrual irregularities and the bladder.—*Homœopathic Journal of Obstetrics*, September.

**HELONIAS** is useful for suppression of the menses when the kidneys are congested. It seems as though the monthly congestion, instead of venting itself, as it should, through the uterine vessels, has extended to the kidneys, giving rise to albuminuria. The urine is scanty and turbid.—*Homœopathic Journal of Obstetrics*, September.

**VIBURNUM PRUNIFOLIUM IN UTERINE HÆMORRHAGE.**—"The following two cases will be of rather more than ordinary interest from the very nature of the cases. One lady threatened abortion at about the three-month period of gestation; there was prolonged and stubborn hæmorrhage, which, though conquered in a measure by ordinary means, was followed by urgent and distinct abortive symptoms, which, however, persisted in spite of ordinary methods of rest and treatment; quickly yielded to the use of the liquid extract of *viburnum prunifolium*, one drachm doses, frequently administered. She is now nearly in her normal carrying state of health. The other threatened miscarriage, the symptoms, which were very urgent, and rapidly progressive, entirely yielded to the same dose of *viburnum prunifolium*. These are only two of many which, however, I scarcely anticipated would be followed by such immediate and satisfactory results."—Dr. Richard F. Owen, *Homeopathic World*, October.

**MEDICINES IN SURGERY.**—In the October *New England Medical Gazette*, Dr. C. S. Pratt has an article under the above caption, from which we briefly excerpt as follows:

**Chilblains.**—Ten or twelve cases had been given *pulsatilla* 3x, all reported immediate relief. One gentleman who claimed to have been tormented so that he could not sleep for hours, night after night, was cured, for that winter, by two doses.

**Boils and Abscesses.**—If seen before pus has formed, *belladonna* 1x, internally and fluid extract of *belladonna* externally, will nearly always abort.

A young man with two large boils on his wrist and arm, within an hour after the first dose of *belladonna*, felt relieved of the pain, and within two days all pain and swelling were gone.

Mr. M. complained of swelling, heat and throbbing pain on the side of the left knee. It enlarged rapidly and grew red. There were the usual constitutional symptoms accompanying the formation of a large abscess. The *belladonna* treatment began its quieting work at once, and within a week, without any pus forming, the knee was well.

**Sores.**—A man of seventy-eight had a sore on his leg for two years. The leg from the knee to the ankle was literally black; there was an open sore on the ankle about the size of a silver dollar. On the leg there were large patches of thick scabs, from which oozed a sticky fluid. Lachesis was prescribed for the black leg and graphites 3x, the scabs with sticky fluid, using no external applications. In less than two months the skin was smooth, but a little dark-colored, which more lachesis cured promptly. Though seventy-eight, this patient has had no return for four years.

**Scrofulous Ophthalmia.**—Two small bottles of sulphur 3x, cured a girl of five of scrofulous ophthalmia, with photophobia, lachrymation, agglutinated lid, ulcers on the cornea (severe pain and swelling of the lids made the case an aggravated one), after a famous New York oculist had failed with tonic treatment and local washes.

**Carbuncles.**—Nearly all can be nipped in the bud with *bryonia*.

A man of sixty-five had a large carbuncle on the back of the neck. The pain, swelling and soreness were gone in four days under *bryonia*.

A man of thirty-five had a carbuncle the size of a hen's egg on the back of his neck, unbroken, tense and painful. *Bryonia* and *hepar sulphur* 1x, brought this to a close (unbroken, painless and flat) in about a week.

A lady of sixty had a carbuncle fully six inches in diameter, covering the whole back of the neck. Did well under  $\frac{1}{2}$  grain doses of *hepar sulphur*. It was seen too late for effective abortive treatment.

**Tonsillitis.**—If seen early can generally be rapidly cured, and, indeed, aborted sometimes, by the use of *guaiacum* 1x and 2x. Chronic tonsillitis can generally be greatly modified, if not cured, by *baryta carbonica* 6x.

**Orchitis.**—A young man recovering from measles was attacked by a severe inflammation of the left testicle. *Pulsatilla* 3x, internally, and *belladonna*, fluid extract, locally, set him right in three days.

**Tumors.**—The cutting pains of fibroid tumors of the womb can be greatly lessened, and at times stopped entirely by the use of *calcareo iodata* 2x and 3x, and the progress of these growths can be checked and their size decreased by the daily use of the same means.

About three months after the birth of a child, a lady consulted me for a painful tumor of the breast, which she believed to be a cancer. It was about the size of a

large cocoanut. The surface of it looked red and angry. The pains reached to the arm and down the side. It was very hard. It went away under *calcareo iodata* 3x and *hepar sulphur* 6x.

Three weeks after the birth of a daughter, a lady found in her breast a hard, painful bunch, with no signs of suppuration. Dr. Nichols recommended *hepar sulphur* 6x. Within a week the lump disappeared.

A small tumor on the upper lip of a little girl readily yielded to *calcareo iodata* 3x.

*Hæmorrhoids*.—A number of cases have met prompt relief by the use of sulphur 6x, *æsculus* 3x, *nux vomica* 6x and *hamamelis*. A wash of *calendula*, *hydrastis* and *belladonna*, an excellent one. Locally, ice water is most useful.

*Erysipelas*.—*Belladonna*, if indicated, rarely fails. Twenty-drop doses of the tincture of the chloride of iron has given the best results, quelling the trouble in two or three days, and should be repeated hourly if necessary.

CLINICAL NOTES.—*Bellis perennis*.—Effects of sudden chill from wet cold, especially when drinking cold liquids after being over-heated.

*Lac caninum*.—Migratory rheumatism with alternation of sides; shifting pains.

*Nuxmoschata*.—Muscular rheumatism from protracted exposure to cold and damp; fugitive drawing pains worse in repose, better from warmth; left shoulder and right hip especially affected.—*California Homœopath*, October, 1890.

CALCAR. CARB. IN PERIOSTITIS.—Mrs. B., a well-nourished woman set 61, suffered for two years from swelling of the left wrist-joint and the neighboring soft parts; apparently a periostitis of the bones of the wrist.

She formerly suffered much from cardialgia accompanied by distension of the epigastrium. Menses always copious and antepoing. She cannot stand wet and cold; warmth of the bed is agreeable to her. The various functions are about normal. The joint is only slightly movable. On August 9, 1889, she received calcar. carb. 10, a dose every 7th evening. On November 4th the normal mobility of the joint had been restored, while the swelling was less.—Dr. Kunkel, in *Allgem. Homœop. Zeitung*, August 7, 1890.

AURUM IN EXOPHTHALMIC GOITRE.—In 1873 a lady in the forties came under the care of Dr. J. Kafka, suffering from exophthalmic goitre. She had blonde hair mixed with gray. The eyes protruded very much, and she had a quite hard goitre that made her neck very broad. The carotids could be seen to pulsate violently; and on the sides of the neck dilated veins were quite distinct. On inspecting the thorax, dilated veins could be seen in the clavicular regions and above the mammæ. The cardiac region was markedly swollen and violently shaken by the exceedingly powerful impulse of the heart. On placing the hand upon the ribs, epigastrium and even the posterior wall of the thorax, the impulse of the heart could be felt. Respiration much accelerated. Every motion of the body, laughing and mental changes, increased the frequency and violence of the strokes of the heart; ascending stairs and moderate elevations produced the same effect.

Examination of the heart showed that it was enlarged. The lungs and abdominal organs were normal. The second sound of the heart was abnormally loud and had a metallic timbre, heard loudest at the apex. One moment the heart-beats were 120 to the minute, while the next they would run up to between 150 and 160; motion or animated talking determining this increase.

As no complications could be found the diagnosis, according to recent pathology, was that nervous weakness was the cause of the phenomena. At different times phosphor. 3, pulsat. 3, calcar. carb. 6, and spigel. 3, quieted the heart's action so that she would pass several weeks in comfort.

In the summer of 1873, she was persuaded to undergo iodine treatment for the disease, and in August she was very pale, much emaciated, and dispirited with great weakness. The iodine was then stopped, and she received china, 1, three doses per day, which gradually caused an improvement in her strength. Later the inordinate paroxysmal palpitation returned, and aurum mur., 3, two doses per day was administered.

This remedy was selected because of the marked nervous depression that existed since taking the iodine. The usually lively and talkative lady was now generally quiet and introspective, cried without cause, and was haunted with the thought that

she must die soon. The slightest noise, the least motion, and when she was suddenly spoken to, the palpitation of the heart and carotids would set in with violence, so that she feared she would faint. The pulse was 160 per minute, and the second sound of the heart was so changed that it resembled a hammer striking an anvil (metallic timbre). In a short time its frequency would change, but the diastole was always the stronger.

To sum up, the reasons for administering the aurum were the following symptoms: hypochondriacal or melancholy condition of mind with tendency to crying, or also fear of death (nervous depression), alternating with nervous erethism and excessive palpitation of the heart with accentuated second sound of the heart of metallic timbre.

Already after the first dose there was a marked quieting of the impulse of the heart and a calming of the mental condition. She again became talkative and in good spirits. Motion and mental changes were better borne. In two months the eyes were much less prominent, and the goitre had decreased in size and did not pulsate any more; the heart had become so calmed that the two sounds were of equal intensity and the metallic quality had disappeared.—*Allgem. Homœop. Zeitung*, September 18, 1890.

**THUJA IN DISCOLORATION OF THE NAILS.**—While examining a patient, Dr. Pascal noticed that her finger nails had a black discoloration at their tips which she claimed was not due to lack of cleanliness. They had the appearance as though they had been dipped in ink, and she knew of no explanation of the peculiarity. The nails were not of uniform thickness, but had irregular elevations here and there. Thuja 3, was given for 14 days, and then thuja 2, for 8 days with the result of removing the discoloration completely.

To improve the nutrition and cure the unevenness, graphites 3, was administered for 40 days afterward and produced a complete cure of that condition, too.—*Allgem. Homœop. Zeitung*, September 18, 1890.

**PULSATILLA AND SILICA IN PURULENT OTITIS.**—A 27-year-old woman, who had suffered as a child from degeneration of one of the cervical lymphatics and a left-sided purulent otitis that was followed by hardness of hearing, complained for two months past of violent pains in the left ear in consequence of a sea bath. Pus began to be discharged the day after the bath. When first seen, the following symptoms were noted: purulent discharge from the left meatus and tympanum, the drum having a large perforation through it; the discharge having an offensive odor. She is very sensitive, is always worse in summer than in winter; complains of constant sweating in the axillæ; menstruation too profuse and too early. Sulphur was prescribed, and later calcar. sulphur., without result, although they were used for two months. Then pulsat. 1, and silica 3, were given, each being used three days and then replaced by the other, bringing about a rapid cure.—*Allgem. Homœop. Zeitung*, September 18, 1890.

**NATRUM MURIAT. IN GASTRALGIA.**—An elderly lady had suffered for six months from pains in the stomach with vomiting. Ulceration and cancer were excluded by the examination. She is not hysterical. The pains generally appear in the afternoon and persist until 2 A.M. During this time they become so intense that she would cry out, although she is not unusually sensitive. While the pain was so intense she could neither sit nor lie, but was compelled to stand in a bent position. Between the attacks she had a heaviness as though stones were in the stomach. Every motion, even the slightest, aggravates the pains intensely. She received bryonia 2, and arsenic. 3 in alternation, with relief that did not remain permanently. Natrum mur. 30, one dose, was then given. The pains immediately began to improve, so that in eight days they had disappeared and have not recurred, although almost a year has passed since the single dose was given.—Dr. Moser, in *Allgem. Homœop. Zeitung*, October 30, 1890.

**TREATMENT OF ACUTE AND CHRONIC CORYZA.**—*Acute form Nux Vom.*, is preferably indicated at the beginning of coryza, especially when accompanied with a violent headache and epistaxis. Alternation of dry and fluent coryza is also an indication for this remedy. Dose: 3 gtt. of 3x dilution in 200 grammes of water; a spoonful every hour or every two hours.

*Mercurius and Sulphur.*—The alternation of sulphur and mercurius at the very beginning of a coryza has been recommended by Espanet, and we have to recognise



the fact that this alternation constitutes an excellent treatment. *Dose*: 2 gtts. of 6x dilution of each, in 125 grammes of water for each drug. To be taken alternately, a spoonful every two hours.

*Euphrasia* is indicated when the coryza is very abundant, non-corroding, associated with a conjunctivitis with abundant lachrymation as seen in measles. *Dose*: The first dilutions, even the mother tincture, given as above recommended for *nux vom.*

*Allium Cepa* is also indicated in very acute coryza with lachrymation. *Dose*: 1x, 2x or 3x dilution.

*Arsenicum*.—A reliable drug in the treatment of acute and very intense coryza, especially when the discharge is of a burning and corroding character. *Dose*: As *allium cepa*.

*Dulcamara* is the principal remedy in coryza neonatorum. This is an absolutely clinical indication. *Dose*: Same as *allium* and *arsenicum*.

*Chamomilla* and *Belladonna*.—These two drugs find their indications in certain coryzas associated with excessive pains. Those pains are located in the maxillary and frontal sinns, and when they are very intense are accompanied by anxiety and restlessness. *Dose*: in two separate glasses of water add a few drops of the 3x of each, and give alternately every hour, or even every half-hour.

CHRONIC FORM.—*Pulsatilla* is indicated in coryza as soon as the discharge becomes thick. The characteristic of this drug is the loss of smell and taste. It is also indicated in chronic coryza when the nasal mucous membrane thickens; ulceration of nares; obstruction of nasal passages; secretion of thick, yellow, or green and fetid mucus. *Dose*: It should be used in low dilutions and even the  $\phi$ , two to three doses *per diem* for several weeks.

*Silicea* is a very important drug in the treatment of chronic coryza; chronic form of stopping of the nose with thickening; redness and ulceration of nasal mucous membrane, with a purulent fetid discharge having the odor of decomposed meat. *Silicea* holds good also in another variety of chronic coryza, alternately fluent and dry associated with sneezing. *Dose*: The 30th dilution is the most convenient potency for this drug. To be taken twice daily during eight or ten days, and after four days rest begin again.

*Hepar Sulphur*.—The action of this drug is analogous to that of *silicea*; both of these drugs may be alternated. The most particular symptoms indicating *hepar* are obstruction of nares with itching; pains and crusts in the nose, or, on the contrary, muco-purulent discharge having a bad odor, sometimes mixed with blood; there is great swelling and redness of the nose and loss of smell. *Dose*: Usually we give the 3d or 6th dilutions in the same manner as *silicea*.

*Graphites*.—This drug is indicated as well when there is a puriform discharge with crusts in the nose, ulceration of nares associated with impetigo of the face; the discharge is fetid even to the patient himself; which excludes totally any idea of a true ozæna, in which the faculty of smell is entirely lost. *Graphites* is also indicated in cases of obturation and painful dryness of the nose. *Dose*: Same as *hepar*.

*Kali bichromicum*.—The ulceration and destruction of the parietes of the nasal fossæ is the more characteristic of slow poisoning by the bichromate of potash. This perforation is preceded by an acute and violent coryza with sneezing. Serous discharge and lachrymation, swelling and redness of the nose; later, patients blow hard and elastic plugs. The smelling faculty is sometimes lost. *Dose*: First dilutions.

*Kali hydriodicum*.—The well-known action of iodide of potash upon the mucous membrane of the nose, of the frontal sinus and of the conjunctivæ naturally is indicated in the treatment of acute coryza. Its action upon the scrofulous affections should make us think of it in the chronic coryza, so habitual in scrofulous patients, and the clinical experience has proven, in fact, that *kali hydriodicum* is a very good remedy in the treatment of coryza in all periods. *Dose*: Same as the previous drug.

*Conium mac*, *calca. carb.* and *sulphur* have been employed by some physicians with success in chronic form of coryza, but the indications of those individually having not been given, we cannot but recommend to the attention of practitioners.—Dr. P. Jousset, in *l'Art Medical*, October, 1890.

CALCAR. CARB. IN GANGLION.—Dr. Kunkel was consulted in December, 1887, by a clerk for a ganglion on the back of the right hand. He had suffered from hip disease in childhood, in consequence of which spontaneous luxation had occurred.

Now he has an extensive ganglion. Sweats easily, particularly about the head; frequent toothache, worse from a draught, better from covering up warmly; feels generally worse in damp weather; the hand cannot be used, is painful, both spontaneously and from motion.

Calcar. carb., 10, a drop twice daily was prescribed.

On March 1st, he reported that the swelling had increased in size at first and then decreased, so that he can now use his hand without any trouble. The remedy was thereupon continued and the swelling almost entirely disappeared.—*Allgem. Homœop. Zeitung*, August 7, 1890.

**RHUS TOX. IN SCIATICA.**—M., male, had suffered for four or five weeks from sciatica, for which allopathic physicians had been unable to do anything. He was lying in bed resting on his left side and moving his right leg constantly. Electricity had been employed with but slight relief. He could not stay in bed at night, particularly after midnight, but had to get up and walk about; constant thirst, drinking little at a time; frequent voiding of scanty urine that smelled strong; could not lie on the back or the right side; aggravation during windy weather; icy coldness of the affected part. Arsen., 10, was prescribed for two days without result, when he mentioned that he was worse in damp weather and from damp air. Rhus tox., 10, was then given for three days without much relief. On the night of the third day he obtained ten hours' sleep and in two days more went about his business (in the open air).

From some cause he had a slight relapse that was rapidly removed by rhus tox.

**ARSENICUM IN CARBUNCLE.**—A widow aged 51 years, had always been well until within ten days before coming under treatment. Her illness began with cold shivering, disgust for food, weakness and burning pains in the neck, and in the back part of the head when straightening it. Sleep was bad on account of the pains. She cannot bear to lie on her back; pulse quick; tongue not coated; hard blue-red swelling of the size of an egg on the back of her neck, a little movable on the underlying parts, many small white spots on the same, but no secretion. Pains particularly violent in the night. Arsenicum album, third centesimal dilution, was prescribed. In four days pus began to ooze from two small openings, and the pains in the back of the neck decreased considerably. In ten days the swelling was soft all over. In one month she was entirely cured.—Dr. Oscar Hansen in the *Homœopathic World*, October 1, 1880.

**NABULUS ALBUS IN DIARRHŒA.**—From an article appearing in the *Transactions of the Maine Homœopathic Medical Society*, on "Applied Materia Medica," we glean that Dr. M. S. Briry has cured a number of cases of diarrhœa with *nabulus albus*. "It will have good effect in cases of chronic diarrhœa, with aggravation in the morning and immediately after breakfast; stools profuse and sometimes feel hot in passing. It will be found useful in those cases in which sulphur and natrum-sulphuricum seem to be indicated, but fail to cure.

"**NUPHAR LUTEA** is another remedy for diarrhœa, in which the aggravations are in the morning. I have used it a number of times with good results in cases of morning diarrhœa in women."—Dr. M. S. Briry, *Trans. Maine Med. Soc.*

**CHELIDONIUM IN GASTRIC CATARRH?**—"Alvin G., aged forty-five, has had catarrh in the nose for years and the same in the stomach; has been told that he has cancer of the stomach. Tenderness over the stomach, with sinking, gone feeling, at times reaching a state of painful anguish; all the symptoms relieved from eating. If he doesn't eat at such times he often vomits a little bile and belches much gas, with bitter taste; bowels very costive, with alternate diarrhœa. I had tried a number of remedies with but little good, until *chelidonium* 6x at once relieved all the symptoms, and for ten years now he has been free."—Dr. C. M. Foss, *Transactions of the Maine Medical Society*, 1890.

"**PRACTICAL POINTS.**"—We abstract the following from an article by Dr. Geo. M. Ockford, in the November *Southern Journal of Homœopathy*:

**Hay Fever.**—Every summer, cough and wheezing breathing. Cough preceded by asthmatic condition. Always aggravated by first sleep. *Aralia racemosa* promptly relieved.

**Neuralgia.**—Four weeks duration, occipital, facial, coming in paroxysms. *Bryonia* 3x lessened frequency of attacks. *Bryonia* 200 completed the cure.

*Gastrodynia in Nervous Female.*—After every meal, pain and sick feeling; nervous, fidgety feeling in feet in evening. *Zincum 12x* relieved.

*Sleeplessness in Pneumonia.*—After chloral and opium had been given unsuccessfully to induce sleep in a pneumonia patient, *lachesis 76m* gave sleep in half an hour.

*Malaria.*—A fourteen-year old boy, after much bathing, had fever and ague. Paroxysms came early in the morning, 2 A.M. to 3 A.M. Short chill, long fever, profuse sweat, thirst absent in all stages; slight headache; drowsiness and occasional vomiting. *Thuja 30* cured.

**REMEDIES FOR INFANT DIARRHŒA.**—Dr. Wm. Owens, Sr., in the October *American Homœopathist*, gives the following remedies and indications for diarrhœas in children.

*Arsenicum.*—Stools thin, watery, scant or copious; may be green, yellowish, white, or like rice water, or of undigested food after eating; rapid emaciation; great thirst, takes but little water at a time.

*Belladonna.*—After a chill; stools green, slimy.

*Bryonia.*—Changes to hot weather; following cold drinks; stool yellow, bilious, slimy.

*Chamomilla.*—Following cold drinks; yellow, bilious, slimy, watery, like beaten-up eggs, griping, colicky pains in bowels; worse after passion.

*Ipecacuanha.*—During hot weather, with nausea, vomiting of food and watery substances.

*Mercurius Dulcis.*—Discharges acrid, dark, grassy-green, frequent, painful.

*Veratrum Album.*—Discharge large, watery, frequent; thirst great; cold or clammy extremities.

*For Changes of Weather.*—From warm to cold. *Dulcamara.*

*For Teething.*—Chamomilla, belladonna, kreosote, mercurius vivus, sulphur.

*For Sour Stools.*—Rheum, chamomilla, lycopodium.

*For Gushing or Explosive Discharges.*—Secale, croton tiglium, phosphorus.

*Lienteric Diarrhœa.*—Arsenicum, nux vomica, croton tiglium, oleander.

*Croton Tiglium.*—Discharges large or small, loose, watery, burning greenish, yellow liquid, papescent, come with force; slight straining afterward; heat in the mouth; wants cold things.

**BRITISH MEDICINAL PLANTS.**—In the November *Homœopathic Physician*, Dr. Alfred Heath continues his remarks concerning British medicinal plants, from which we abstract the following:

*Actæa Spicata.*—Not proven, but was mentioned by Ruckert as a remedy in certain cases of neuralgia, characterized by violent tearing and drawing rheumatic pains in one side of the face, extending from the teeth of the upper jaw through the molar bone as far as the temple. It is acrid, cathartic and poisonous to children. Allopathically it has been used as an external application to inflammations, and with much success in tumors of the breast.

*Pœonia Officinalis.*—Formerly used as an anodyne, also as a tonic, and as a remedy for epilepsy. Pœonia produces, in healthy people, many varieties of pain, headaches, boring, darting, tearing, gnawing, sticking with pressure, aching; rushes of blood to the head; restless sleep, with fancies and dreams; languor, weariness on walking; heaviness in the chest and limbs in the open air; languor and heaviness of the limbs, relieved after eating; great prostration in the evening; symptoms similar to epilepsy—rush of blood to the head, nausea, hissing in the head, vanishing of the senses, fainting after walking up-hill, vertigo during every motion, constant reeling sensation in head, staggering to and fro, heat in the head, crawling in the forearm as of something alive, transitory creeping in the fingers and sides.

**REMEDIES FOR GLAUCOMA.**—In a paper by Dr. A. B. Norton, on "Acute Glaucoma," after recapitulating the local treatment necessary in the disease, gives the following list of remedies that may be of service in connection with other measures.

*Aconite* may be of service at the commencement of an acute attack when we have much heat, redness and burning pain in the eye, together with fever and other symptoms of the drug generally.

*Belladonna* may occasionally be indicated in severe throbbing pains, aggravated by noise and light, together with the flushed face.

*Bryonia* is a remedy to which much credit is given. The eyes feel full. Sharp,

shooting pains through the eye and head. Eyes sore to touch and on moving them. Halo around the light.

*Cedron* may relieve a severe shooting pain over the eye.

*Colocynth* has a severe cutting pain in and around the eye, which is relieved by pressure.

*Gelsemium* is one of our principal remedies in this disease, and is, perhaps, more frequently used than any other, and yet there seems to be no especial characteristic symptoms upon which it is given, hence we come to the conclusion that its use has depended upon the fact that clinically it has proven its value, as many favorable results are recorded from its use.

*Nux vomica* has been used more in the later stages of the disease, when atrophy of the nerve is present, the morning aggravations and other symptoms of *nux*.

*Osmium* is a remedy that has proven of value in the hands of some and from its symptoms should be given a more thorough trial. It has sudden, sharp, severe pains in and around the eye. Dimness of vision; objects seen as in a fog. Halo of various colors around a light.

*Phosphorus* is of value after an iridectomy, and in some cases is useful early. Halo around light. Objects appear red.

*Prunus spinosa* has a very severe pain in the eye, as though it were being pressed asunder; sharp shooting pain in the eye and side of head.

*Rhododendron* has severe periodic pains in the eye, aggravated before a storm.

*Spigelia* will also often relieve the sharp, shooting pains in the eyes and head. The pains are worse on motion and at night.

Apis, eserine, mercurius and thuja may be needed.—The *New England Medical Gazette*, November.

**SUGGESTED REMEDIES FOR DISEASES OF THE PANCREAS.**—In the October number of the *North American Journal of Homœopathy*, there appears an article "On Diseases of the Pancreas," by Dr. Samuel Lilienthal, from the last paragraph of which we abstract the following:

In diabetic affections resulting from disease of the pancreas, *nux vomica* is highly thought of, also after the abuse of liquors, high living, over-indulgence in society life. In *lycopodium* we may meet with pancreatic calculi and jaundice; wasting of the upper part of the body with the œdematous swelling of the lower limbs. Deventer calls attention to *chelidonium* and *carduus marianus*. In the latter, after the abuse of alcoholic drinks, especially of beer, and with *arsenicum* the former shares its relief by hot drinks, but while the *celandine* may be more indicated in the earlier stages, *arsenic* may be more indicated in the latter stages, when emaciation and mental depression prevail. *Bromide of arsenic*, not too low. *Aurum* and *nitric acid*, when pancreatic atrophy originated in syphilis and melaturia followed. *Phosphorus*, with its fatty degeneration and venous stasis, the emaciating *iodium*, and the deeply penetrating *plumbum* must not be lost sight of.

**PHOSPHORUS.**—"For cases in which cold food relieved and warm food aggravated, I have found phosphorus 4x useful."—Dr. C. M. Foss, *Transactions of the Maine Medical Society*, 1890.

**TARENTULA IN CHOREA.**—Dr. C. M. Foss, in the *Transactions of the Maine Medical Society*, 1890, says: In two cases of chorea in children, with a continuance of the symptoms when sleeping, *tarentula* cured. I gave them both in the 30th potency, but as one of them continued to grow worse, I gave that one *tarentula* 8th, with amelioration of the symptoms at once.

**CUPRUM IN EPILEPTIC CONVULSIONS.**—"John P., aged forty-five, has had epileptic convulsions for years, so that it had brought on great nervous excitability with trembling at times. He had two or three convulsions a week; they came on more frequently at night. *Cuprum* 2x relieved so that it is now over six months since he has had a convulsion, the last one being very light. This case received *cuprum* 30 at first, but the convulsions increased while taking it. This is the second case in which *cuprum* 2x has worked well; one of the cases has not had a convulsion for over four years.—Dr. C. M. Foss, *Transactions of the Maine Medical Society*, 1890.

**CHIONANTHUS.**—Headache, with intense bruised feeling of the eyeballs and abdominal pains.—*California Homœopath* November.

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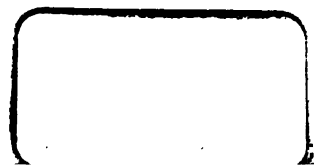








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